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Homelessness:
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and Beyond

Spring/Summer 1992

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A Journal of the
John W. McCormack
Institute of Public Affairs

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New England Journal of Public Policy

A Journal of the John W. McCormack Institute of Public Affairs
University of Massachusetts at Boston

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Editor's Note

Padraig O'Malley

Walking into Harvard Square in the late evening, you will pass them: a man, perhaps in his mid-twenties, with a duffel bag, taciturn behind a sign that simply says "Help," crouched on the sidewalk against a railing of the Old Burying Ground; two more men, with long hair and the gaunt, disinterested features and spasmodic movements of serious substance abusers, who call out, halfheartedly at best, for a dime or a quarter, on the steps of the Unitarian-Universalist Church; another two men, one older, roughly hewn, and practiced, the other timid, uncertain, and apologetic, in front of the Harvard Coop; a woman, whom you will fail to notice at first because she is so smartly dressed, but whose suitcase and travel cart, always at her side, will in time give her away, in front of Gnomon Copy on Mass. Avenue; and another woman, also minding her meager chattels, her obviously derelict circumstances in sharp contrast to her low-key, carefully articulated solicitations, her polite, almost polished expressions of thanks, just outside Holyoke Center. Seven faces of homelessness, invisible yet exposed, ghosts on the urban landscape who have lost their ability to haunt us.

For a while in the mid-1980s, when they were "new," they held our attention, but when it became clear that their presence among us was not the result of some temporary aberration in the socioeconomic mix but rather a manifestation that something in the country had gone seriously wrong, we disengaged. The thought that we, too, might be just a paycheck or two away from homelessness is too unbearable, too anxiety provoking for comfort: the suggestion that the system itself is at fault and that no amount of tinkering at the margins will fix matters, in fact, that nothing short of a complete overhaul will, flies in the face of our received wisdom. It is too unsettling to contemplate for a people not given to undue contemplation: denial is the preferred panacea for the unpalatable. But, of course, it is just such fears, fueled by, and in turn fueling, a recession that has spilled its insidious bile into the guts of the middle class which underlie our uncertainty about the future, our uneasy questioning of assumptions long the cherished cornerstones of our national myth: that if you educate yourself and work hard and live virtuously, you will get ahead and stay ahead.

Padraig O'Malley is senior associate at the John W. McCormack Institute of Public Affairs, University of Massachusetts at Boston.

This special issue of the *New England Journal of Public Policy* will, I hope, add to the vigor of that questioning. Our aim is to make the policy dilemmas related to homelessness understandable to policy practitioners, policymakers, elected officials, government managers, the business community, journalists, academics, humanists, students — and the larger public; to draw attention to the web of complexities that entangles the major policy concerns; to expose some of the more fanciful and convenient shibboleths homelessness incubates; to provide a showplace for innovative research in the social and medical sciences that charts new paths and alerts us to new possibilities, enhances our understanding of the core problem, builds new frameworks to explore policy alternatives, and provides prescriptive agendas for policymakers.

Today, much of public policy debate takes place in a social vacuum. This is partly because policy issues are often rather arbitrarily assigned to particular and seemingly unconnected disciplines that put a premium on maintaining their separate baronies of intellectual hegemony, and partly because of our own too-pervasive proclivity for compartmentalizing in order to simplify. One of the goals of the *New England Journal of Public Policy* is to invade, as it were, these baronies, to liberate the policy issues held hostage there and release them into a broader, more human context, one that accentuates the idea of connectedness as the hallmark of continuity in public affairs.

For this special issue, therefore, we have drawn on contributors from all quarters — from people who work with the homeless, human service advocates, social workers, mental health professionals, housing experts, the medical community, psychologists, sociologists, anthropologists, and “ologists” from many other fields. Some contributors do not agree with one another, and I have encouraged them to pursue their disagreements passionately, in the belief that the clash of opposing voices invigorates our thinking and makes us re-examine our own suppositions, that out of the hot crucible of debate emerges the distillation of ideas germane to finding new ways of looking at old dilemmas. But the emphasis throughout is on the homeless as human beings — we get behind the numbers and make the homeless a living part of the issue.

Hence the voices of the homeless themselves.

Lars Eighner wrestles from scavenging the essence of a contemplative spirituality that puts the madding crowd's pursuit of consumer materialism into an unsettling perspective: “I find from the experience of scavenging two rather deep lessons. The first is to take what I can use and let the rest go by. I have come to think that there is no value in the abstract. A thing I cannot use or make useful, perhaps by trading, has no value, however fine or rare it may be. . . .

“The second lesson is the transience of material being. . . . I do not suppose that ideas are immortal, but certainly mental things are longer-lived than other material things. . . .

“Many times in my travels I have lost everything but the clothes I was wearing . . . The things I find in Dumpsters, the love letters and ragdolls of so many lives, remind me of this lesson. Now I hardly pick up a thing without envisioning the time I will cast it away. This I think is a healthy state of mind. Almost everything I have now has already been cast out at least once, proving that what I own is valueless to someone.”

S.B. (a pseudonym) immerses us in his pain but asks for no easy pity: "I have written [my] story, not only to share with others, but to help myself. I returned to drinking [again] after four months of being sober. I can't stop and am scared, and will be sick and desperate soon. This is a hard disease, and I know I can't be helped until I want to help myself."

Susan Fowler, on turning twenty, rages at the world, her despair erupting from unfathomable depths of loneliness and isolation few of us have experienced and fewer still would survive: "I just can't find any answers to my problems. I think I'm going over the edge. See, one of these days I'm going to kill myself. I mean really do it. See, the other times I was just looking for someone to care, take me home with them, but now that I'm 20 I find out nobody gives a fuck about me and I'm too old for a foster home. My life is over before it even starts. When I was 17 the social workers could have helped me find a home where someone cares and appreciates me, but the motherfuckers didn't care either. I wish I knew what to do. The only way out is to die. This [world] seems to me where hell is. If there's a place worse than this world I hope I never go."

Other voices, too — Thomas Newman, Betty Reynolds, Edward Baros, A.E.S., D.B., B.S., Vince Putnam, Steve Johnson, Robert Pavel, Ray Hall, Jr., Kathie Boulanger, Dean Hamlin — give poignant testimony to the human search for dignity in the face of extraordinary adversity, to how some struggle and endure and to how some struggle and fail, to how amorphous and unpredictable is the line between the two, to how success is often as much a question of happenstance as of determination.

To be homeless literally means that you have no home to live in, that you are without the reference point to which you instinctively turn to define who you are in relation to the larger order of things; that you are deprived of your sense of place and privacy, your sense of belonging, of rootedness and community, of being part of a social configuration that gives context to your aspirations and purpose to living — all essential elements of identity, of self-worth, all inextricably related to the functioning of the psyche and the meaning of life. To lose your home is to lose a part of yourself, of the meaning of your life; it induces a profound sense of loss and the grieving that inescapably accompanies loss.

"Any severe loss may represent a disruption of one's relationship to the past, to the present and to the future," Marc Fried writes in "Grieving for a Lost Home." "It is the disruption in that sense of continuity which is ordinarily a taken-for-granted framework for functioning in a universe which has temporal, social and spatial dimensions." The loss of an important place "represents a change in a potentially significant component of the experience of continuity."¹ The sense of belonging is severed; the focus of consequential interpersonal relationships is destroyed; the sense of spatial identity — that sum of experiences grounded in spatial imagery and the spatial framework of social activities which is fundamental to human functioning — is traumatized; the sense of human self-image, of shared human qualities, is undermined.

Questions of definition and numbers continue to eviscerate the public policy debate. David Rochefort and Roger Cobb argue that "the ongoing struggle over how to define homelessness as a public problem — one in which diverse outlooks, intents, and philosophies shape the positions of different actors — enriches the policymak-

ing dynamic but also diffuses it by producing confusion over the promise and very appropriateness of proposed interventions.” This much we can be sure of: estimates of the number of the nation’s homeless range from a low of 300,000 to several million, depending on the counting criteria employed. Twelve percent of the homeless are adults with children, 10 percent are children, and 78 percent are single adults. Of all homeless people, 58 percent are single men; between 33 and 40 percent are women and children.

However, only a quarter to a third of the homeless are permanently homeless. The majority are episodically so — periods of homelessness alternating with periods when people have access to housing. In *Address Unknown: The Homeless in America*, James Wright estimates that, on any given night, a half million people are homeless, leading him to conclude that the *annual* homeless population is in the region of one and a half million.² In *Down and Out in America: The Origins of Homelessness*, Peter Rossi distinguishes between “the literally homeless” and “the precariously housed.”³ The literally homeless are people who don’t have “customary and regular access to a conventional dwelling,” while the precariously housed are poor people who are about to be evicted, or thrown out of a house by relatives, or who can’t meet higher rents. According to Rossi, “The most believable estimate is that at least 300,000 are homeless each night in this country, and possibly as many as 400,000 to 500,000.” He estimates that another 4 to 7 million Americans are so poor as to be precariously housed.

A 1991 report for the U.S. Conference of Mayors, to which Mayor Raymond L. Flynn alludes in the Foreword, surveyed twenty-eight major cities whose mayors are members of the Task Force on Hunger and Homelessness, drawing a demographic profile of the urban homeless population. About 50 percent are single men, 35 percent are families with children, 12 percent are single women, and 3 percent are unemployed youth. Children constitute 24 percent of this homeless population, African-Americans 48 percent, whites 34 percent, Hispanics 15 percent, Native Americans 3 percent, and Asians less than 1 percent. Only 18 percent are employed in full- or part-time jobs.⁴

In the country at large, substance abusers account for close to 40 percent of the homeless population, and mentally ill people for approximately one-third. The failure of deinstitutionalization, the relative lack of comprehensive community alternatives, and the demolition of single-room-occupancy (SRO) units in many large cities during the 1980s (during the late 1970s and 1980s, one million rooms — almost half the total — were lost) left many of these chronically isolated individuals particularly vulnerable to becoming homeless. About half of the homeless receive some form of social service assistance; the other half manage to survive without government assistance of any sort.

Aggregate statistics, however, often conceal the nature and extent of the real problem. In New York City, a mayoral commission which studied the problems of the city’s shelter system found that 80 percent of the homeless men housed in the city’s vast armory shelters and 30 percent of the adults in shelters for families abuse drugs or alcohol. Drug use is as much a symptom as a cause of homelessness. Although many of the homeless have a drug problem before they enter the shelter system, others develop a problem once they are in the system — drugs, after all, anesthetize the pain. The city’s homeless, the commission found, were hobbled by interrelated afflictions: extensive poverty, mental illness, AIDS, domestic violence,

and lack of education and job skills. Only a minority of the homeless, it concluded, need housing just to get back on their feet. ("While the call for 'housing, housing, housing' is misguided, so are the calls for 'services, services, services.' The truth is that both are necessary.")⁵

Approximately one third of the entire homeless population are veterans, a figure that is an appalling indictment of the entire array of Veterans Administration services. According to the National Coalition for the Homeless report on homeless veterans, they are better educated (80 percent graduated from high school and one-third either attended or graduated from college) than the at-large homeless population; the majority have been homeless for less than a year; and approximately one-half have a substance-abuse problem.⁶ Vietnam veterans account for 40 to 60 percent of homeless veterans, while those who suffer from posttraumatic stress disorder are more likely to become homeless than other Vietnam veterans.

Robert Rosenheck, Catherine Leda, and Peggy Gallup evaluate the impact of two programs which, since their inception in 1987, have treated 40,000 homeless mentally ill veterans. Success rates, they conclude, are "modest . . . reflect[ing] both the severity of psychiatric disorder and social dysfunction in this population and the limited ability of health care programs to address the full range of problems faced by the homeless mentally ill, even when services are specifically tailored to meet their needs."

In *Without Shelter: Homelessness in the 1980's*, Peter Rossi contrasts the "old" homeless of the 1950s and 1960s with the "new" homeless of the 1980s.⁷ The demographic and social characteristics of homelessness are decidedly different. The homeless of the 1980s suffer a more severe form of housing deprivation than their counterparts of thirty or forty years ago: they include a sizable number of women — one homeless person in ten is a woman; they are younger — the average age of a homeless person has dropped from somewhere in the mid-fifties in the 1950s and 1960s to the mid-thirties today; they are much worse off — in constant-dollar terms, the average income of today's homeless person is at best a third of what it was thirty years ago; and a disproportionate number of them come from racial and ethnic minorities, in contrast to the mostly white homeless population of earlier years.

However, Ellen Bassuk, who compares and contrasts the nature and extent of homelessness during 1890–1925 and the present, demonstrates that the homeless populations of both eras have many similarities, with the exception of the growing number of homeless families over the last decade. "Then and now," she concludes, "homeless people tend to be young, single, and . . . have fragmented social supports and a history of dysfunctional family relationships." She uses the comparison to underscore a point: that the causes of homelessness are systemic, and that our unwillingness to address these systemic ills virtually ensures the existence of homelessness.

Pamela Fischer adds another layer to our understanding of the social entrapments that perpetuate propensities to homelessness. She asserts that "victimization appears to be embedded in homelessness at least in its contemporary form, if not throughout history. It arises from patterns of behavior deeply rooted in virtually every aspect of social life, but is perhaps most visible in disadvantaged populations among which homeless people fare worst. Victimization is pervasive and its effects devastating and long lasting, resulting in culturally molded patterns of behavior transmitted generationally that are extremely difficult to reverse. Although homelessness itself fosters violence, victimization has been shown to cause homelessness

directly through events that propel individuals onto the street, as well as more insidiously. Chains of events beginning in childhood render individuals unable to cope with demands of adult life, thus predisposing them to becoming and remaining homeless.”

Homelessness shows no sign of leveling off. Estimates of the rate of annual increase vary between 10 and 38 percent. Among the twenty-eight cities surveyed by the Conference of Mayors’ Task Force, twenty-five reported increases averaging 13 percent over the previous year’s requests for emergency shelter, whereas the number of emergency shelter beds increased, on average, by only 4 percent. As a result, three quarters of the surveyed cities had to turn away homeless people because there were no resources — at least 15 percent of the requests for shelter went unmet.

Disagreements over definition and numbers reinforce other disagreements. Liberals argue that homelessness reflects, for the most part, the structural deficiencies of the economy and the government’s inadequate housing, income, and health care services for the poor. Conservatives argue that it is the homeless themselves who bear the primary responsibility for their predicament — hence the “drunk, addicted, and just plain shiftless” and the Reagan “Well, we might say, homeless by choice” paradigms. At the public policy level, however, disagreement over the relative importance of economic and health-related factors continues to fuel a controversy that has raged for some years among those involved with homelessness. Many mental health professionals believe that programs to help chronically ill homeless persons have, at best, short-term benefits if they do not also provide regular clinical care. Many advocates, on the other hand, insist that focusing on mental health or other service needs is a distraction obscuring the basic issue: the lack of affordable housing.

Viewing homelessness through the prism of a single socioeconomic or health indicator, however, refracts our understanding of the problem. The causes of homelessness are multiple and self-reinforcing; they are intrinsically interrelated, not separate and exogenous — the function of many variables, many of which are functions of one another. “These variables exert their influence simultaneously,” write Rochefort and Cobb, “as part of sequential chains and as greater or lesser components of hierarchical structures. Varying problem definitions arise from the way that different observers interpret the available data within this framework of analytical possibilities and from the relative importance they assign to the identified causal factors.”

(Russell Schutt postulates the homelessness equation with succinct elegance: homelessness is a function of the level of poverty in relation to the supply of affordable housing and the level of personal disability in relation to the supply of social services and supports. “Accordingly,” he states, “homelessness cannot be understood solely by studying homeless persons; the social policies and institutions by means of which we respond to homelessness also help to define its nature.”)⁸

The economic and social data are damning. In the 1980s the economy underwent a structural transformation that was characterized by an outflow of previously high-wage manufacturing industries to low-wage countries, leaving in their wake low-wage service industries. In *The Great U-Turn: Corporate Restructuring and the Polarizing of America*, economists Barry Bluestone and Ben Harrison document the consequences. They report that 54 percent of the jobs created between 1979 and

1987 paid poverty-level incomes or less, 34 percent paid middle incomes, and 9 percent paid high incomes. In contrast, in 1979 low-income jobs accounted for just 31 percent of all jobs, middle-income jobs for 65 percent, and high-income jobs for just 4 percent. The trend is unmistakable: the broad job base of the middle class has been eroded, creating a larger "at risk for homelessness" population, an increasing number of wage earners at the housing market margin.⁹ According to a Children's Defense Fund study, families in which the head of household is under thirty have experienced a 25 percent decline in median family income since 1973. Half of all black children live in poverty. Children under eighteen years of age make up 38 percent of the nation's 33 million poor.¹⁰

The nation's economy is skewed in all kinds of undesirable ways, increasing inequality, squeezing the middle class, and raising the specter of a society polarized into two groups: the haves and the have-nots. In the late 1980s, labor accounted for 80 percent of national income; today it accounts for 67 percent. The share of national income (47%) going to the richest 20 percent is the highest since the late 1940s; the share (4%) going to the poorest 20 percent is the lowest. And perhaps most alarming, one in ten Americans uses food stamps.

Between 1977 and 1989, according to a study prepared by the congressional Budget Office, the average income of families in the top one percent of all wage earners increased 77 percent in real terms; the income of a typical American family — that is, a family in the median of the income distribution — increased a mere 4 percent; while the income of the bottom 40 percent of all families actually declined.¹¹ In short, three quarters of the increase in total family income during the boom days of the 1980s went to the richest one percent of families — the rich, indeed, have gotten richer, and homelessness is perhaps more a question of too many people chasing too little income than we have heretofore imagined.

Couple these developments with record levels of corporate and government indebtedness (during the 1980s the country went from being the largest creditor nation in the world to being the largest debtor nation), federal deficits, adverse trade balances, a woeful insufficiency of capital for private investment (the government consistently absorbs about three quarters of private and business savings to meet its debt obligations), a banking system in disarray, and you begin to get the full picture of the Reagan economic legacy. To compound the problems of the rapidly proliferating economic underclass, in real terms the purchasing power of welfare, Aid to Families with Dependent Children, and most other social welfare benefits is about half what it was twenty years ago.

The housing situation is even bleaker. Structural changes in the economy have resulted in growing numbers of poor people who are unable to pay rents or mortgages that would make investment in low-income housing profitable. Yet only one person out of every four living in poverty is able to find subsidized housing — one of the smallest percentages in the industrialized world. Some 6 to 7 million low-income renting families received no housing assistance whatsoever. Meanwhile, as rents tripled between 1970 and 1983, the income of renters only doubled. As a result, by 1985 one out of every four renters paid more than 50 percent of his or her income for housing, and some estimates put the national housing shortage for households earning under \$7,000 at 4.1 million units. Moreover, the Reagan administration all but eliminated Section 8 of the Housing and Community Development Act of 1974,

which provided low-income renters with housing certificates that guaranteed landlords the difference between a tenant's rent and 30 percent of his or her income.

Most major cities have more boarded-up houses than there are homeless. The federal government commitment to publicly owned and assisted housing has practically disappeared. Between 1981 and 1989, federal expenditures for subsidized housing declined by 80 percent, from \$32 billion to \$6 billion, and total federal housing starts declined from 183,000 in 1980 to 20,000 in 1989. In the United States, public housing accounts for an insignificant 1.5 percent of the total housing stock, in contrast to Great Britain (27%), the Netherlands (43%), Federal Republic of Germany (20%), France (16%), and Sweden (35%). In short, in James Wright's words, the essence of the problem is "too many poor chasing too few affordable housing units."¹² Although the National Affordable Housing Act of 1990 provides some funding for housing assistance for the poor and for the preservation of the existing inventory of public and subsidized housing, as Jim Tull indicates, it hardly begins to meet current needs — it does not even restore federal funding for housing to the level of the pre-Reagan years.

The fault, of course, lies not in our stars but in ourselves. Some of the homelessness is unquestionably attributable to our attitudes toward government intervention to redress inequities in the social arena — and our attitudes toward poor people. Compared to our counterparts in industrialized countries, we are less likely to favor the government in the role of social arbiter, still clinging to the notion that the best government is the least government and that social problems, therefore, should not fall within its purview. Similarly, with regard to taxes, we pay a considerably lower share of our national income, particularly personal income, than the citizens of much of the industrial world, but we are truculently resistant to the idea of paying higher taxes even when a demonstrated need for them is evident.

Our attitudes toward the poor are more complicated, perhaps, but nevertheless negative. There is an implicit endorsement of the assertion that the poor are somehow at fault for their poverty, a too-ready willingness to blame the victims, a too-naïve belief that every American who has the pluck and the patience and a capacity for hard work can make it into the economic mainstream, that the American dream is there for those who dare to succeed. It is, of course, gibberish, the stuff of myth, but with shattering societal repercussions. When you add the poison of racism to the brew, attitudes harden in their disapproval, politicians bash welfare mothers, and we walk serenely in our righteousness.

In *On the Fringe: The Dispossessed in America*, Henry Miller finds little to distinguish between our response to the homeless today and to the "wandering poor" of earlier times. The basic attitude is "harsh, unsympathetic and — all too often — draconian in its severity. . . . [Yesterday's homeless person was] whipped, branded, jailed, transported, indentured or executed; in less harsh times he was scorned, shunned, harassed or pushed out of the community. Today the vilification of the homeless is couched in a language of surface neutrality; he or she is 'mentally ill,' 'alcoholic,' 'drug-addicted,' 'pauperized'" — subtle and not so subtle forms of depersonalization.¹³

"A homeless person suffering from a psychiatric illness or an addiction," writes Ellen Bassuk, "is not always viewed as someone who has a disorder . . . Instead the

affliction becomes a metaphor for a host of evils; it serves as testimony to the individual's unworthiness and becomes a cause of condemnation."

We are, Thomas Byrne Edsall and Mary D. Edsall postulate in *Chain Reaction: The Impact of Race, Rights, and Taxes on American Politics*, a nation at war over conflicting visions of itself: "One [is a vision] of individual initiative and equal opportunity . . . the other [a vision] of welfare dependence and anti-egalitarian special preference. . . . At stake," they write, "is the American experiment itself, endangered by a rising tide of cynicism and alienation, and by basic uncertainties as to whether or not we are capable of transmitting a sense of inclusion and shared citizenship across an immense and diverse population."¹⁴ "America," Shaun O'Connell admonishes, "needs to be reminded of the nation's original idea of community, best expressed by John Winthrop in [his 1630 sermon] 'A Model of Christian Charity.'"

"We must delight in each other," Winthrop said, "make each other's condition our own, rejoice together, mourn together, labor and suffer together: always having before our eyes our commission and community in the work, our community as members of the same body."

How weakly Winthrop's exhortations echo in the corridors of power and the living rooms of the affluent! And what a cynical commentary on our public life that Ronald Reagan would shamelessly invoke the pristine translucence of Winthrop's shining metaphor of "a city upon a hill" as a beacon of community for all Americans while his administration betrayed its ideals, systematically excluded the homeless from the American covenant, dismissed their situation as being one of choice, revealing what O'Connell calls "the darker side of American Puritanism, the impulse to expel and punish those who are unable to affirm the common faith."

But to excoriate Reagan alone would be to miss the larger point: something has gone profoundly wrong when a country, the self-proclaimed greatest nation in the history of mankind — begrudges its children the food they need, even in the face of overwhelming evidence of that need, and simultaneously burdens them with having to bear in the future the cost of its own excesses.

In the end, the homeless are visible symbols of our decline as a nation, and we resent them for it. "Man's inhumanity to man / Makes countless thousands mourn!" the poet Robert Burns wrote some two hundred years ago. Today, we mourn not.

In the light of more recent and continuing research, the emphasis in many of the articles in this issue of the *New England Journal of Public Policy* is on questioning the status quo and on debunking many of the assumptions policymakers adopt when they develop their agendas and design their programs. Despite almost universal acknowledgment that the homeless must have access to some form of transitional housing, more specifically shelters, in the short run at the very least, the shelter system as remedy comes in for sustained criticism. Some articles declare that it will ultimately create more problems than it solves, that it perpetuates rather than alleviates homelessness; others argue that there is a propensity on the part of civil authorities to believe they have discharged their public obligations once they build enough shelters to house their homeless populations, when in fact they have become merely more proficient at concealing them from public view, lowering the threshold of public awareness to the acute urgency of the larger social and economic problems and the need for long-term remedy.

Kostas Gounis examines the persistence of shelter dependency in the New York City shelter system. Residents interpret the use of all available resources, regardless of their intended functions, according to their current, shelter-based needs. As a result, "instead of fulfilling their objectives in assisting shelter users to find appropriate housing in the 'community' and connect them to adequate clinical and social services, shelter-based programs tend to become part of the shelter and an elaboration and expansion of the shelter's technologies of control." Homeless people become entrapped in the shelter. "The more they adapt to the demands of shelter living, the more difficult their journey back to a normal life. . . . The obstacles that prevent homeless people from rejoining the mainstream," he concludes, "are the effects of a state of captivity, not the symptoms of a disease."

These sentiments are powerfully — and passionately — reiterated by Kip Tiernan, the founder of Rosie's Place, the first shelter for women in the nation. "Our 'burnt offerings' become alternatives to justice — shelters and soup kitchens and food banks, some of which I started myself," she writes. "For the past several years I have spoken out about setting at liberty those who are oppressed. Maintenance efforts threaten to re-create the almshouses and the orphanages of the nineteenth century. The Band-Aid solutions are wreaking social havoc. We have already seen the results of raising children in the unstable and unholy and impermanent environments of shelters and welfare hotels. They not only expose our children to violence and criminal activity, but they also serve to break down traditional family roles and discipline. And they ultimately can cause mental and physical anguish that frustrate any normal development. Ah, you are probably saying, she doesn't like social workers. I don't dislike them. They simply haven't changed anything, any more than I have. To continue what we are doing might perpetuate the problem, not solve it, and we have to look at that."

The New England Shelter for Homeless Veterans developed a working philosophy that specifically addresses itself to these dangers, the emphasis being on creating a structured environment that rebuilds self-respect and self-confidence. It uses a military regimen, with veterans organized into "four platoons and one company. Each platoon, consisting of twenty-five veterans, is led by a staff counselor platoon leader (a fellow veteran) who daily addresses the individual needs of the platoon."

The shelter, its founder, Ken Smith, and James Yates write, "resisted the trap into which many large shelters fall — that of warehousing the homeless. [We] didn't want to become an 'enabler' to homeless veterans. [We] wanted to provide as many services as possible in order to give veterans every opportunity to return to the mainstream." In keeping with this philosophy, the shelter adopted a policy that requires each veteran, after securing a permanent bed, to find part-time employment (a minimum of twenty-four hours per week) or enroll in some type of educational program, either vocational or academic, within twenty-one days. If the veteran fails to do either in the allotted time, he has to give up his bed and go back on the waiting list.

Anne Lovell examines the complex and frequently misstated relationship between mental illness, homelessness, and the provision of social services. She cites compelling evidence to show that surveys measuring psychiatric states among the homeless tend to inflate rates of mental illness among them, and that needs determined by using rates of psychiatric disorder do not coincide with the needs expressed by homeless people themselves. "By now," she writes, "enough surveys have established

the consistent finding that homeless persons do not necessarily express a need for the mental health resources service providers and researchers assess them as needing. They also order their needs quite differently from the way professionals do. . . .

"Rather than interpreting homeless persons' reluctance in seeking or accepting mental health services on the basis of a universal notion of need," Lovell says, "we might do well to view such expression of autonomy as a critical consciousness of the situation. The low priority they give to psychiatric care may reflect conflicts between the value systems of two worlds or dislike or inability to tolerate the rigidity of organizational structure and time, as well as the centrality of basic needs for shelter, food, and so forth. Refusing to 'hear' such needs has adverse effects on service planning and may lead to extreme consequences, such as creating absolute and meaningless categories of mentally ill homeless. Rather than interpreting the expression of non-mental health needs as resistance, the context in which they are voiced should be examined. This points to the way mental health services are organized, the multiplicity of agencies a homeless person must deal with, and the continual shrinking of resources."

She goes further, urging us to challenge the very concept of need that underlies much of policy research. "Using psychiatric status as an indicator of need presents a further danger. It promotes a circularity by which the supply defines the demand. That is, by defining the needs of homeless persons in terms of psychiatric dimensions and symptoms, the service itself — hospitalization or treatment — becomes the social goal. This circularity in turn legitimates and reinforces the existing system (or nonsystem) of services while pre-empting the possibility of other types of responses."

Paul Carling offers one kind of solution. After analyzing the traditional approach to mental health systems to meeting the housing needs of individuals with severe and persistent mental illness, including those who are homeless, he identifies an alternative approach or "paradigm shift" that views people with mental illness as citizens rather than as patients, with attendant rights, responsibilities, and needs similar to those of all citizens. "In this situation, people with mental illness should be given the opportunity to participate actively in the selection of their housing arrangements from among those living environments available to the public."

We know a lot more about the homeless today than we did at the beginning of the 1980s: we recognize that different homeless people have different needs; that the services single mothers require are much different, for example, from the services adult single men require; we acknowledge that homeless people who are substance abusers or mentally ill or lack education or basic work skills need programs tailored to their specific needs.

What we should do in the short term is transparently self-evident: establish aggressive outreach programs to bring the homeless who are eligible for welfare support under the cover of the safety net (Peter Rossi, in *Down and Out in America*, reports: "Almost all the research on the homeless in the 1980s has shown that few of them participate in the welfare programs they appear to be eligible for by virtue of their financial plight and their disabilities"¹⁵); move the most severely disabled mentally ill from the streets and shelters into total care institutions and release the chronically mentally ill from hospitals only when there are strong assurances that

supportive living arrangements are available; subsidize shelters according to their quality, thus providing incentives for shelters to improve their accommodations and services.

The more important foci of what must be addressed in the longer term are also in place: provide labor market opportunities for young people, especially minorities, through public employment programs; phase out emergency shelters, especially the mass dormitory shelters in the cities; encourage the maintenance and expansion of commercial SRO hotels and rooming houses for single adults; mend the holes in the social welfare net with broad, encompassing, humane definitions of what constitutes disability; make aid available to families who take care of dependent adults in their households.

There is no lack of proposals, creative thinking, or innovative programs, as most of the articles in this volume make abundantly clear (see Jessica Segré; Ellen Nasper, Melissa Curry, and Elizabeth Omara-Otunnu; David Mehl and Mary Ellen Hombs; and Peter Dreier and Richard Appelbaum, for example), albeit philosophical differences continue to make their impact felt. Shelter as a right to all who need it is coming under increasing scrutiny.¹⁶ In 1990, Washington, D.C., voters repealed the city's right-to-shelter law. A city ordinance now limits the length of stay in shelters to thirty days for single people and ninety days for families.

Philadelphia has gone even further. Since 1989 it has halved the money it spends on the shelter system and the number of people in shelters. The city, which does not shelter drug abusers who refuse to participate in recovery programs, conducts random urine tests in shelters to monitor performance. Shelter residents must save 60 percent of their income, whether from work or welfare, and pay another 15 percent of it for shelter. New York City will continue to provide shelter as a right, but the mayoral commission recommends that permanent housing be provided only to those who complete self-help programs. Los Angeles, rather than building shelters, gives vouchers to the homeless, which they can exchange for housing at SRO hotels. Many of the new emphases reflect the concerns of some advocates that the homeless themselves must take partial responsibility for getting out of homelessness, especially when substance abuse is involved.

But in the we-will-help-only-those-who-want-to-help-themselves dispositions to which some advocacy groups are increasingly leaning, conviction can easily drive out compassion. Kathleen Hirsch, in *Songs from the Alley*, makes the point eloquently: "The many chronic alcoholics and drug abusers among the homeless population can no more be disowned by us (or by advocates for the homeless who all deny their existence) than they can be sentimentalized. All have been victims of early violence, and most have suffered from the lack of real opportunities to overcome its worst effects. Their families have exhausted their abilities to aid them. Their habits are deeply entrenched.

"Yet what keeps most of them entrenched are the haunting memories of their previous failed efforts to overcome addiction and hold on to meaningful relationships. [Many have] tried sobriety so many times with such disappointing results that [a] voice inside [them] tells [them] any attempt now is doomed from the start."¹⁷

The addictions to drugs and alcohol mirror the larger addictions of our society: to acquisitiveness, possessions, consumerism, the glitter of the gaudy bauble — and we have our own deeply entrenched attitudes to break down, the one most resistant to

change being “an unwillingness [to own up] to the bankruptcy of some of our dominant social values, which foster these addictions.”

Sheila Rauch Kennedy illustrates how grassroots efforts have forged the coalitions needed to address homelessness at the local level. “The greatest challenge of the 1990s,” she writes, “may be to incorporate the lessons of these community initiatives into the mainstream of America’s housing providers.” Richard Ring, Pine Street Inn’s executive director, argues for “broad-based coalition[s] of people from all walks of life united by a genuine desire to help people in obvious need”; coalitions that serve as “a constituency for homeless people, a large and generous source of voluntarism and financial support, and as a political force of its own”; others make the case for public/private partnerships, for increasing the role of the nonprofit organizations, which are better equipped than municipal bureaucracies to administer homelessness programs, for keeping the scale of effort at human proportions, for involving the business community at a direct level.

All worthwhile arguments for worthwhile efforts. But if we are to drive a stake into the heart(lessness) of homelessness, all are contingent on our collective commitment to the precepts of community: “There are no shortcuts to community, to support, or to relationship,” Kathleen Hirsch concludes. “Families that have been forced to deal with a homeless relative have long since lost the luxury of complacent detachment or sentimentalized concern. They know that the homeless once had homes and once belonged to the neighborhoods. They know that the homeless are not an anonymous aggregate but are individuals, each related to us in a vital and intimate way. . . .

“The only real change occurs when we invest ourselves in the lives of others: by alleviating the loneliness of a solitary neighborhood child . . . sharing our skills; easing the plight of [others] who can’t buy private solutions to the problems we all share, such as lack of child care; contributing time and money to educational, housing, and work opportunities for those who haven’t had our good fortune; listening with an open heart to the songs from the alley. These are the investments that will yield real change. Nothing else, nothing less. The solution to homelessness begins at home.”

Some years ago, *CBS Sunday Morning* did a program on Rosie’s Place. In one poignant scene, an old woman named Dorothy, a one-time Rockette, pulled off her boot and shook it furiously. Out fell a key, which she thrust with some defiance at the camera. “See,” she said, “I still keep the key to the place I used to live in.”

A small thing, a key, a thing we take for granted, a small thing that separates the homeless from the housed. Next time you reach for it, remember. ♪

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Foreword

Raymond L. Flynn

Imagine a hypothetical disaster befalling America's cities. A bomb, perhaps; or a ferocious hurricane; or an earthquake. Two to 3 million Americans lose their homes. We know that, daily, the evening news and the major newspapers would feature stories on the number of people victimized by the disaster. Many Americans would volunteer to help their neighbors in need, and many community agencies and local governments would come to the rescue, but the public would rightly expect the federal government to play a leading role in repairing the human and physical damage. The president and Congress would act swiftly to declare a national emergency and to funnel relief into the cities.

In fact, a national disaster *is* occurring in America now, and what is especially horrifying is that few of our nationally elected leaders are even addressing the crisis, let alone proposing serious solutions. By some accounts, 2 to 3 million Americans are homeless. Although some dispute this figure, the fact remains that the number of homeless Americans is growing.

Each year, the U.S. Conference of Mayors undertakes a survey of America's cities to assess the trends regarding homelessness, hunger, and poverty in urban America. For five years I was privileged to chair the Task Force that sponsors this survey. What we have found — a rising tide of homelessness in America — reflects a national scandal.

This is the most pressing moral issue facing our country. I hope that this special issue of the *New England Journal of Public Policy* will help catalyze public debate and help build political support for an all-out effort to attack economic and social injustice, which is at the root of our homelessness dilemma.

I hope, too, that the analyses provided in these articles will help reverse what some perceive as a growing backlash against the homeless population. Most Americans are decent, compassionate people who are ashamed of our nation's growing poverty and injustice. But as the homeless problem grows, some Americans — encouraged by misguided media accounts, columnists, talk show pundits, and even some government officials and candidates — have grown impatient at the sight of homeless people on the sidewalks and subways of our cities. There is at times a tendency to blame the victim.

Raymond L. Flynn, elected mayor of Boston in 1983, was reelected in 1987 and again in 1991. Chairman of the U.S. Conference of Mayors' Task Force on Hunger and Homelessness for five years, he is currently president of the U.S. Conference of Mayors.

In truth, homelessness is a result of economic injustice and misguided public policy — and policymakers who have turned their backs on human needs. America is in deep crisis. Families, workers, and businesses across the country are hurting. During the 1980s, the incomes of America's richest one percent (660,000 families) increased by 77 percent, while the incomes of the bottom 40 percent of families declined. The basics of middle-class life — owning a home, getting a college education for the children, having access to decent health care, even holding a steady job — are now increasingly out of reach.

Furthermore, as of February 1992, over 8.4 million Americans are out of work — 1.3 million more than a year ago. The number of poor Americans has increased by over 2 million — to more than 33 million — in the past year alone. This includes one in five children. A recent Harvard University study revealed that the decline in housing prices during the past year has not relieved the housing shortage for poor and working-class Americans. Most cities are facing severe fiscal traumas and a few have even fallen into bankruptcy.

Homelessness is a symptom of these larger economic and social forces. But the problem has been compounded by the federal government's failure to address the basic needs of the poor and disadvantaged in at least three areas.

First, federal cutbacks have dug huge holes in the so-called safety net. Job training, education, human service, and other programs have been slashed, making it more and more difficult for low-income Americans to lift themselves out of poverty. *Second*, housing programs have been dismantled by over 70 percent. The number of affordable housing units has declined, while the number of poor has grown. *Third*, deinstitutionalization emptied America's mental hospitals without providing adequate resources for community-based facilities. As a result, many shelters have become, de facto, America's new mental institutions, but without the resources to provide adequate care.

We have made some progress on the housing front in recent years. In the late 1980s, Congress passed the McKinney Act to provide funds for housing, health care, and social services for the homeless. In 1990, Congress passed a comprehensive housing bill that includes funds to protect the inventory of existing subsidized housing, help first-time home buyers, and modernize public housing. I am particularly pleased that the bill incorporates legislation — the Community Housing Partnership Act — that is modeled on our successful Boston program, which provides federal funds to community-based nonprofit housing developers.

But we cannot rest with this victory. It is a good first step, but it is hardly the solution. The level of resources authorized by these bills is woefully inadequate for the tremendous need that exists across the country. We are still spending a good deal less than we were ten years ago; not surprisingly, the crisis is much worse. Despite this reality, some segments of our society argue that the responsibility for dealing with homelessness should be shouldered by private charity, by volunteers, and by local government. The people who work on the front lines of the housing crisis — the shelter providers, the tenant activists, the community development corporations, and the soup kitchens — are the real heroes of this generation. But it is clear that charity — soup kitchens and shelters — is not the answer to this national problem.

True, these groups *have* sought to fill the gap left by Washington's withdrawal. In Boston, we have been able to fulfill our commitment that no homeless person will be denied at least a warm bed, a hot meal, transportation to a shelter, and access to

health care. But our goal is not to create more and better soup kitchens and shelters. We have to eliminate the *need* for soup kitchens and shelters.

Despite heroic efforts, it is simply beyond the capacity of private charities and local governments to solve this crisis. Only the federal government has the kind of resources we need. But if Washington is going to address this problem, it will require a broad political coalition to change national priorities and meet human needs.

In some ways, our work this year is harder than ever, because the nation's economy is in a severe recession and the federal government has a growing deficit. On the other hand, we have witnessed the end of the Cold War, which offers an unprecedented opportunity to redirect our nation's resources and brainpower to domestic needs like housing, health care, education, and the plight of our cities.

If we are going to address homelessness seriously, we need to reorder our nation's priorities. We cannot continue to pour billions of dollars into bailing out the savings and loan industry, providing indiscriminate tax breaks for big business and the very rich, and wasting vast resources in a Pentagon budget to defend our allies against a military threat that no longer exists — while proven cost-effective programs that upgrade the lives of poor and working-class Americans go begging.

We have to reverse the direction of the past decade, during which our economy stagnated while our competitors moved forward. Meanwhile, our federal government failed to address our country's serious economic troubles. It sat on its hands, withdrawing from the problems facing the American people. Even today, our national leaders seem to be completely out of touch with the daily concerns of most Americans. Neither the Bush administration nor Congress has proposed any serious game plan for revitalizing the economy and putting America back to work. There is no relief in sight for the economically squeezed middle class. There is no plan to repair the safety net for American families in need. There is no forward-looking blueprint to convert our militarized economy into a peace economy and to make sure that, in the process, workers, communities, and firms that have relied on Pentagon spending are not victims of the end of the Cold War.

What's needed is a national effort to close the *investment gap* that is at the root of America's economic decline. We have to reverse the direction of the past decade and invest in American jobs, invest in the American people, and invest in American cities.

The end of the Cold War offers us an unprecedented opportunity to invest in our domestic future. The biggest danger facing America today is not the red menace, but the pink slip. We must mobilize Americans around a national agenda for economic growth and justice. 🌱

Homelessness

An Overview

Jim Tull

The homelessness crisis in the United States has reached epidemic proportions as the diversity of the homeless population expands to the point where it resembles the general population. The deepest and most long-standing cause of homelessness is poverty, but there are other forces as well, including the severe shortage of affordable housing (particularly due to urban renewal); deep funding cuts at the federal, state, and local level; the policy of deinstitutionalization; the Vietnam war; and unemployment. A new public policy approach to homelessness is needed, one which addresses these multiple forces and is grounded in the assumptions that housing and a decent standard of living are rights and entitlements. There are several elements to this fresh approach which, taken together, require a fundamental mobilization of political will.

It has been said that a frog immersed in a beaker of boiling water saves itself by immediately jumping from the beaker, but left in cold water that is gradually warmed, the same frog adjusts to the changing temperature until it boils to death. Our country, like the frog who learns to tolerate an intolerable predicament to the point of its own demise, is ignoring the ballooning crisis of homelessness — and the poverty that underlies it — at its own peril. Incredibly, some of our cities have come to resemble what we commonly think of as the Third World. Many of the streets of New York City, for example, can be compared to those of Calcutta, India.

In some areas the plight of our cities — and their homeless — is even deeper than some of the poorest places overseas. Commenting on the warehousing of homeless families in the welfare hotels of New York, Jonathan Kozol writes, “Although I have spent a great deal of time in recent years in some of the most desolate, diseased and isolated areas of Haiti, I find the Martinique Hotel the saddest place that I have been in my entire life.”¹

Much of this sadness, I think, lies in the spiritual poverty and demoralization that plagues many of the homeless in our country, where most people are relatively well off and place a premium on individualism and economic standing, and where the resources needed to solve the problem are so accessible. Too often at the

Jim Tull is codirector of Amos House, Providence, Rhode Island, a hospitality center that provides overnight shelter, free meals, and support and advocacy services.

Amos House men's shelter, in Providence, Rhode Island, I have witnessed the evaporation of a man's dignity and sometimes even his sanity while he searches for another job, having become homeless. Our temporary hospitality tries to shore up a person's sense of self-worth, but the homeless face too many obstacles to their own survival. There is more to having a home, particularly the support it provides, than those of us who have them are able to appreciate. "Even phone-booth vacancies are scarce in New York City. As in public housing, people are sometimes obliged to double-up. One night I stood for an hour and observed three people — man, woman and child — jammed into a single booth. All three were asleep."²

Homelessness is first of all a horrifying experience for anyone to suffer; second, it is an acutely intolerable social condition, like the frog's boiling water, that the rest of us have for some reason permitted to grow and grow.

Counting the Homeless

The homeless have been studied by many researchers, and the nature and scope of the problem has been carefully documented. Nevertheless, the single unanswered question is, How many homeless are there in the United States? No one knows. The shelter population is easily counted, but the only effort to count all the homeless nationwide was that carried out by the Census Bureau in 1990. The census count of homeless people on the street, however, was so low and the counting method so ineffective that the bureau was forced to disavow its tally as a useful count of the population.³ The count was 230,000 people. But as early as 1983, the Department of Health and Human Services estimated 2 million homeless.

Aside from the total number of homeless, however, the fact that the homeless population continues to increase in many of our nation's major cities at an annual rate of 25 percent is cause for alarm.⁴ With no relief in sight, even a conservative count of the current population will snowball year to year at this rate. Equally sobering for many who cling to stereotypes is the staggering number of homeless families in our country. One third of our cities' homeless are families with children.⁵ In Rhode Island, nearly one in four people seeking shelter are children under twelve.⁶ This trend is distressing not only because of the harm caused by homelessness to these children, but also because any war on crime and drugs will be beside the point as long as hundreds of thousands of children in our country are growing up with no home.

Neither is homelessness an exclusively urban phenomenon. Recent attention has been drawn to the increasing number of homeless people, mostly families, in rural America. One survey estimates that 20,000 people are homeless in Ohio's rural areas alone.⁷

Another stumbling block to achieving a thorough count of the homeless, and one reason why public response to the crisis remains so weak, is that most homeless people are "hidden." The Census Bureau might count only shelter and street residents as homeless, but many people are inclined to seek out friends and family when they lose their housing rather than go to a shelter. Unless an indefinite welcome is extended by the hosting friend or family, this doubling-up arrangement is precarious. Many others live in cars and abandoned buildings, and still other homeless people are holed up temporarily in detox wards or prisons, driven there sometimes by homelessness itself and unemployment. I consider people in any of these circum-

stances homeless. They are hidden and uncounted, but their plight adds substantially to the national tragedy, which otherwise amounts for some of those more fortunate to little more than the inconvenience of having to sidestep a sleeping body on their way to work.

Finally, any account of the homeless problem must include mention of those who live on the brink of homelessness. They cannot be counted as homeless but many will become homeless. Of this group, the most identifiably vulnerable are those who face the threat of homelessness simply because they cannot afford their current housing. Basing affordability on the 30 percent of income standard used in federal housing programs, one study found that the cost of renting a one-bedroom apartment (about half of all renter households require an apartment with two or more bedrooms) was unaffordable by over one third of renter households in every state and over half of all households in six states, four of which are in New England (Maine, Massachusetts, Rhode Island, Vermont).⁸ In Rhode Island, a household must earn \$22,000 to afford a two-bedroom apartment. And while families struggle to keep their housing, those having to relocate for one reason or another are forced to pay two or three months' rent up front just to move in. Of those on the edge who have managed to avoid homelessness, it can be said that they have been impoverished by escalating housing costs.

Why So Many Homeless: Clarifying the Issues

While there are certainly competing perspectives on what has brought on the current crisis, there is also some confusion surrounding the problem. The first popular perspective considers the homeless themselves to be the source of the problem. Alcohol and drug abuse, financial irresponsibility, mental illness, divorce, and reproductive habits are among the personal behaviors causing homelessness, according to this view. The more conservative version of this view looks at the problem as a public nuisance to those who aren't homeless and offers solutions that clear the homeless from view and harm. It is generally a response that relies on courts, prisons, and mental institutions and is based on the premise that the homeless are to blame for their predicament and do not deserve a sympathetic response. The more liberal version, while recognizing that some groups and individuals are disadvantaged from the outset, also identifies the homeless themselves as the source of the problem, but offers a more compassionate response that calls for giving personal assistance to homeless families and individuals. The homeless aren't as blameworthy, yet this version does not seriously fault the social structures of their wider communities.

A second perspective attributes the homeless problem to our country's social structures and the values and priorities that sustain them and looks to solutions that include shifting government priorities in the short term and creating fundamental, long-term changes in our political and economic structures. This article focuses on the political causes of, and solutions to, homelessness that reflect this broader perspective.

There is, of course, a real sense in which the truth lies somewhere between these two perspectives. An individual homeless person, for example, might have lost his housing because the rent was too high due to the shortage of low-cost housing and because he spent too much money on alcohol. Those who interpret the problem

solely in terms of personal deficiencies fail to recognize the interplay between the social and personal causes of homelessness. An analogy might be drawn to musical chairs to help expose the error. The second perspective attributes the rise in homelessness during the 1980s primarily to the severe shortage of affordable housing, a product by and large of social policy. There are not enough housing units for everyone. Like musical chairs, a game with eleven contestants competing for ten chairs and a loser who is either slow or unlucky, the housing crisis has meant that some are left on the street. They are left out because they are less desirable tenants, for whatever reasons, than others on the waiting list, or because of bad luck. The first perspective does not address the homeless crisis as a whole, but only the question of why some people are homeless and not others. If a city intersection is missing stop signs, some drivers are destined to collide. We can conclude that a particular driver was intoxicated or not paying attention, or we can put up stop signs and attend to people's driving habits as a largely separate issue.

The Right to Housing

In choosing, as I do, to approach homelessness as a social or political rather than a personal problem, and in making a distinction between perspectives one and two, I assume that the state is obligated to ensure that the basic housing needs of its residents are met. Many perspective one advocates deny that the community is obligated to house its residents, or even its "citizens." While these advocates might concede the musical chairs mistake, they quickly argue that the supply of housing is legitimately a function of free market forces, not government policy. This was Ronald Reagan's position and policy (although he had no problem with the states taking compensatory action in the face of his massive cuts in federal housing aid). With the Housing Act of 1949, Washington announced its goal of providing adequate housing for all American families, but significantly stopped short of declaring that housing is a right and entitlement.

Regarding the question of the right to housing in the context of today's homeless epidemic, there are at least three different positions that can support the view that the problem is primarily one of public responsibility and policy: (1) housing is a natural or human right; (2) housing is not a natural right but should be a legal right because living without housing or without adequate housing is unpleasant for those who have to endure it and has negative repercussions for everyone else; (3) housing is not and should not be a right of any kind and is not a government responsibility, but since the government got into the housing business decades ago and gradually invested up to \$32 billion annually in housing as of 1980, any dramatic downshifting in this growing commitment will cause intolerable dislocation, including widespread poverty and homelessness.

I believe that a community is obligated to provide all residents decent, safe, and affordable housing that is based on current standards and available resources in the community. In the United States today, certain minimal standards of decency are widely accepted, so that, for example, living in a multifamily house is considered adequate and living with rats is not. Undeniably, this nation is capable of ensuring that all its people have housing that measures up to accepted standards. In short, housing is a basic human right, given the housing capacity and relative styles and standards accepted within a community.

Homelessness did not become a cause of widespread concern until the mid-1980s, yet a number of elements contributed to the current crisis that predated the Reagan/Bush period. They are all tied to public policy decisions made at the state, local, and national levels of government. Three of these contributing forces are noteworthy: deinstitutionalization of the mentally ill; urban renewal; and the Vietnam War. These developments, coupled with the housing crisis of the 1980s, interconnect with and overlap one another.

The Mentally Ill Homeless

Deinstitutionalization became a public policy trend in many states during the 1960s. The policy aim was to reduce dramatically the number of patients cared for in mental health institutions, transferring care for them to community mental health centers (CMHCs), where they could be served on an outpatient basis. The policy evolved in response to, among other things, reports of inhumane conditions within existing institutions, the introduction of psychotropic medication capable of regulating behavior outside the hospital, a social and legal trend toward mainstreaming mental health patients and protecting their right to refuse treatment, and the opportunity for states to shift financial responsibility for the mentally ill to the federal government (through new programs such as Supplemental Security Income and Medicaid).

The policy achieved its first objective: in the thirty years since 1955, the number of patients in public mental institutions was reduced nationwide by a startling 79 percent (see Figure 1).⁹ The second goal, which was to provide sufficient care for discharged patients, failed miserably and helped produce an onslaught of homeless people with severe mental illness. Even after this policy's failure was clearly demonstrated, state institutions continued to empty their beds and close down so that the state's financial burden for patients could be shifted to the federal government.¹⁰

Among the nation's homeless, roughly 30 percent suffer from severe mental illness.¹¹ The ongoing policy of deinstitutionalization has been a major cause of this tragedy. Although CMHCs were funded to provide the care that was no longer given in hospitals, many of the promised centers never materialized and the care given by those that did proved inadequate. Some of the reasons are the following.

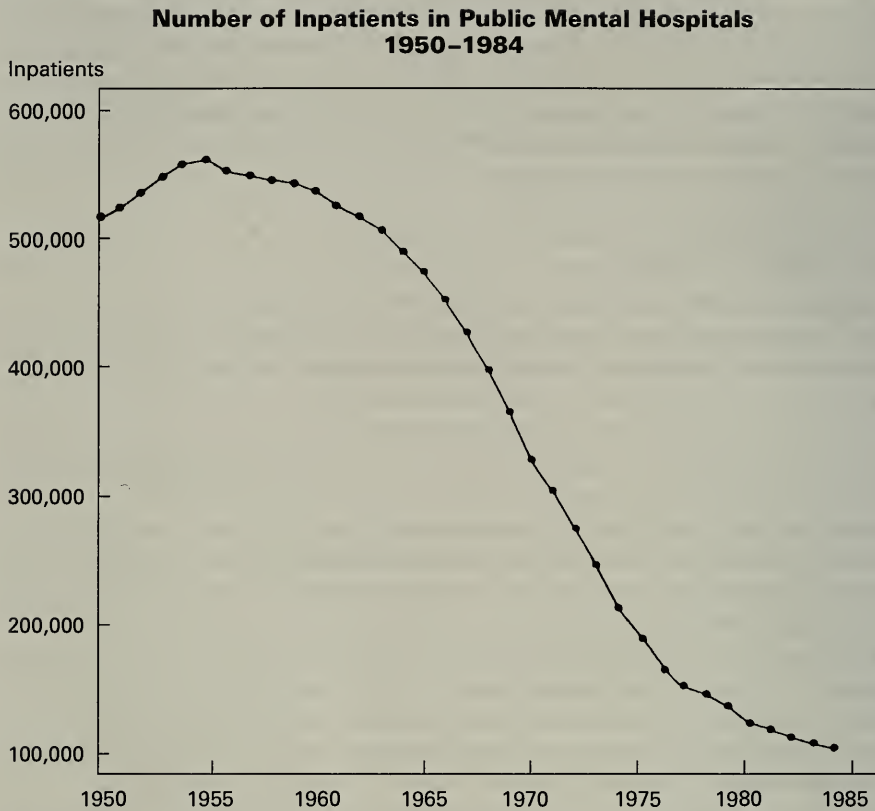
1. The lack of coordination and cooperation between the hospitals discharging patients and the CMHCs expected to care for those discharged.

2. The tendency of many CMHCs to shift their marketing focus from the severe mentally ill to white middle-class patients with personal problems who could pay for counseling (in many places, including Providence, the centers actually changed their name and location to attract the new clientele — see Figure 2).

3. The inability of many patients to conform to outpatient treatment schedules and other demands along with the inadequacy of medication to substitute for residential care.

4. The lure of private practice, which drained too many psychiatrists and other mental health professionals away from treating the poor and severely ill, despite the federal subsidies most professionals received to provide such treatment in completing their training.

Figure 1



Source: Fuller Torrey, *Nowhere to Go* (New York: Harper & Row, 1988), 219–20.

In the massive shuffle of people from hospitals to the CMHCs, many people fell through the enormous cracks created by deinstitutionalization. They became completely lost in the mental health care system and often ended up in prison or on the street.

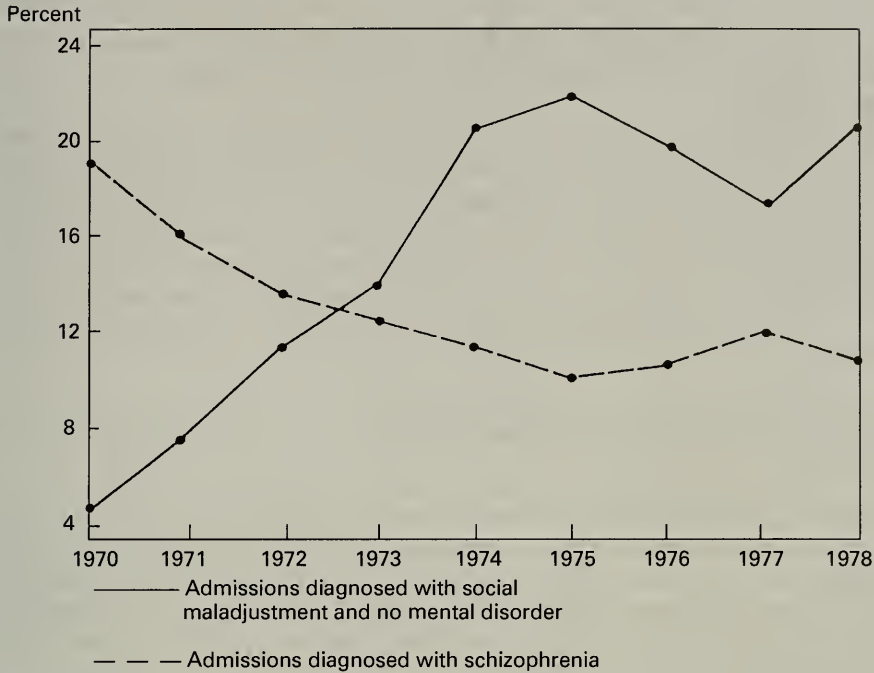
Urban Renewal

Although deinstitutionalization has been a common target of blame for the homeless crisis, other forces contributed to this process before the Reagan-Bush years. One was the conversion of low-cost housing units to some other purpose, beginning in the 1970s and accelerating again in the late 1980s.

Urban renewal (or redevelopment) and highway projects often meant the large-scale destruction of low-income housing units. To make their cities more attractive, state and local officials often applied legal means and invested public funds to replace tenements with upscale apartments, civic and convention centers, office buildings, and roads. Roughly half a million low-rent housing units were lost in the process during the 1970s.¹² Single-room-occupancy units (SROs) were hardest hit because their image contrasted most sharply with the upscale designs of city plan-

Figure 2

Percent of Admissions to Community Mental Health Centers with Diagnosis of Social Maladjustment and No Mental Disorder versus Schizophrenia, 1970-1978



Source: Fuller Torrey, *Nowhere to Go* (New York: Harper & Row, 1988), 219-20.

ners. Between 1970 and 1982, approximately 1,116,000 SRO units, nearly half the total supply, were lost.

Many mental health patients discharged from hospitals from the early 1960s on were able to find this kind of housing if they could not live with their families. The availability of SROs saved deinstitutionalization from its meanest effect: massive homelessness. Although many patients *did* become homeless during the early years of deinstitutionalization, and many who survived in SROs did not receive adequate treatment, the crisis of the homeless mentally ill that we experience today is the by-product of deinstitutionalization and a housing shortage. Put another way, urban renewal squeezed many onto the streets.

Behind the redevelopment steamroller came the dislocating effects of gentrification and speculation. The former involved the conversion of neighborhoods from low-income to middle- and upper-income households; the latter was the practice of buying and selling property simply to profit from rapidly changing market conditions. Often the two forces act together. For example, an investor might cash in on recent public renewal investments in an area, purchase low-cost property, renovate it for the new, higher income residents moving to the renewing neighborhood, and earn higher rents or sell at a profit. The result was displaced low-income persons and inflated housing costs.

The Vietnam War

Deinstitutionalization, together with the disappearance of SROs, left many people homeless who did not have the personal resources to live independently or to compete for available housing. Compounding this was the war in Vietnam. While mental institutions were discharging patients in droves, the war produced an inordinately high number of returning veterans scarred with psychological and substance-abuse afflictions.

Veterans represent a disproportionately high percentage of the homeless population, with estimates ranging from 23 to 33 percent. At least 10 percent of the homeless are Vietnam era vets. The unwillingness of the government to effectively meet the mental health and substance-abuse needs of returning veterans is the tragic result of public policy decisions. The fact that so many Vietnam veterans remain homeless is, in part, the result of the damaging and lingering effects of war and the failure of existing veteran support services to adequately meet these veterans' very serious needs.

The "New" Homeless: Changing Demographics in the 1980s

During the post-World War II years of economic expansion and rising affluence, Americans came to associate homelessness with the relatively few number of skid row alcoholics who roamed the streets in certain neighborhoods of large cities. Typically, they were older men, and aside from vagrancy ordinances and the like there was little public policy response to their plight. These people did not attract much public sympathy.

By the late seventies and into the eighties, however, whole new categories of people became homeless until the homeless population as a whole began to resemble the population of the nation, which is where we are today. In the late seventies and early eighties, young men who were not directly affected by deinstitutionalization or the war were the next category of homeless to be added to the swelling ranks. These new homeless — a disproportionate number of whom were African-American and Hispanic — fell into the streets because of unemployment. As with the other homeless, these unemployed men could not compete for the dwindling supply of affordable housing. Single women were also beginning to appear at shelters at an increasing rate, particularly as victims of domestic violence.

But homelessness did not attract widespread public concern until the mid-1980s, when the numbers began to increase dramatically, with women and children and families constituting the latest categories. By 1986, according to a survey conducted by the U.S. Conference of Mayors, 28 percent of the homeless in twenty-eight of our nation's largest cities were families with children and 15 percent were single women.¹³ By the end of 1990, families with children comprised half of all those seeking shelter in Rhode Island; 27 percent of homeless Rhode Islanders were children under eighteen.¹⁴ In addition to unemployment and the absence of mental health services, the Conference of Mayors report cited the scarcity of affordable housing for low-income people as the most frequently identified cause of homelessness. There is a consensus among homeless advocates that this crisis of affordable hous-

ing, which began in the 1970s and rapidly accelerated in the 1980s, is the most responsible cause for today's homeless epidemic.

The Impact of Reaganomics

It is one thing to lose one's job, income, and then housing, and quite another to find oneself homeless simply because one's housing has become unaffordable and other available housing is also out of reach. This predicament doesn't require a loss of job or even a change of income, but merely a change in landlord or a short-term financial crisis, such as theft. This is one reason why many women with children have joined the bulging homeless population. Public financial support for poor families (AFDC and other assistance) was previously enough at least to maintain a residence. Now, any family living under the poverty line is vulnerable to homelessness. This is the first time since the Great Depression that this condition has plagued our country. In other words, to be poor is reason enough to be homeless.

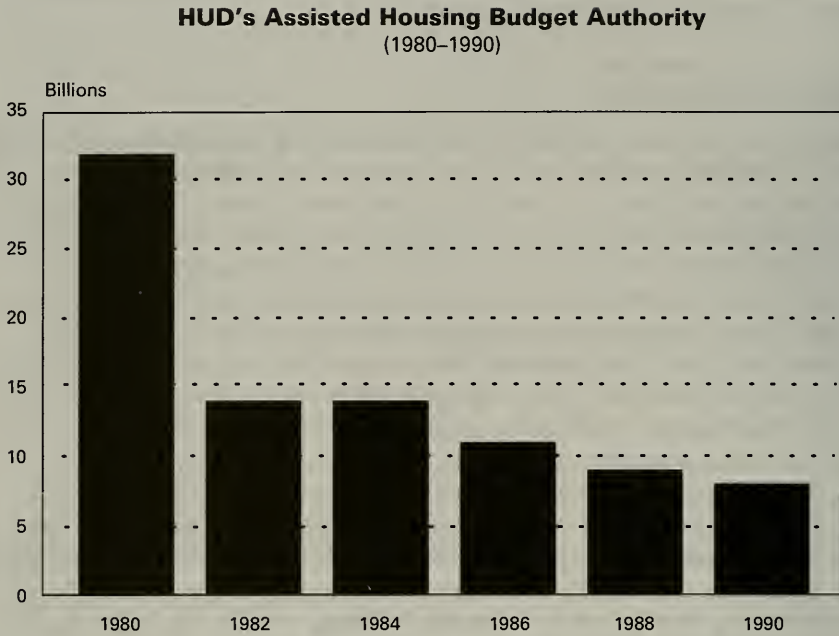
If a severe shortage of affordable housing is the current primary cause of homelessness, the Reagan/Bush administration's housing policies were responsible for creating this shortage. But other administration policies, particularly with respect to taxation, which directly and indirectly produced a substantial transfer of wealth from the poor to the rich, thus leading to greater poverty and a weakened ability to maintain rent payments, also meant homelessness for many families and individuals. Family income decreased while housing costs increased.

Public housing, as we know it today, first appeared as part of the U.S. Housing Act of 1937 in response to the Depression. The federal government's commitment to public housing was significantly strengthened by the Housing Act of 1949, when the number of households in the postwar years was dramatically increasing. This act established the goal of creating "a decent home and a suitable living environment for every American family." Since then, Washington has steadily allocated resources to meet this goal, creating subsidized housing for low-income people up to the current level of about 5 million units. Public housing has been a steadily growing (aside from a slowdown during the Nixon administration), bipartisan commitment, on which the country as a whole and poor people in particular have come to rely.

But in 1980, the federal government led by Ronald Reagan abandoned housing as a responsibility. From 1981 to 1989, government support for low-income housing was slashed from \$32 billion per year to \$7.5 billion, a drop of 80 percent in real dollars (see Figure 3). That this is more of an abandonment than simply a decrease is reflected in the cancerous HUD scandals that drained billions from what little remained in the department's housing budget. Nobody seemed to care. In the words of one senior HUD official in 1985, "We're getting out of the housing business, period."¹⁵

During the 1970s, as the urban renewal steamroller eliminated low-cost, private, nonsubsidized housing, the federal government stepped up its housing initiative to compensate for this loss. But into the 1980s, this public assistance was cut off, and the availability of low-income housing began to drop off dramatically (Figure 3). By 1980, about 170,000 new subsidized units were being produced annually; by 1990, the number had fallen to 25,000 a year. The private sector continued to serve the better-off in the population; for example, less than 8 percent of all new private multifamily housing produced in 1986 rented for less than \$300 a month. These trends

Figure 3



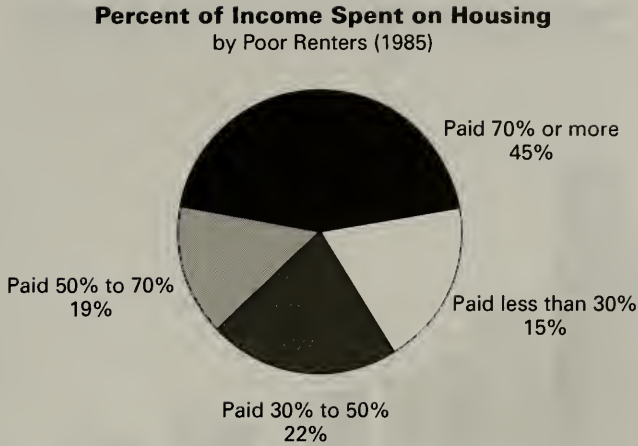
Source: National Low Income Housing Coalition, *Information Bulletin*, 1990.

resulted in a severe net loss of low-income housing. By the late 1980s, over half a million low-rent units were being lost annually. About 2.5 million people were being displaced from their housing every year.¹⁶

The dwindling supply of low-cost housing due to the sudden withdrawal of federal resources, combined with a serious, recessionary slowdown in private construction in the early 1980s, not only displaced poor people onto the street, but further impoverished those who still had housing. Low-income people have been forced to pay an increasingly higher portion of their income on housing as they compete for apartments. The decrease in available housing units translated into skyrocketing rents. By the mid-1980s, nearly one half of all low-income households were devoting over 70 percent of their income to housing (see Figures 4 and 5). In Rhode Island, for example, I know many individuals who hand over their entire General Public Assistance check to their landlords every week. During the past decade, average rents in Rhode Island increased by 153 percent and home prices by 165 percent, while household incomes grew by only 93 percent. One estimate places the number of overcrowded households in Rhode Island at more than 4,000, another sad reflection of the housing crisis.¹⁷

The effects of the recession on the private housing industry also were felt by most middle-income households through increasing housing costs. Rents were going up and rising home purchase prices were making homeownership out of reach for many who would ordinarily have become homeowners. This further burdened low-income people as the cycle of gentrification, speculation, and displacement took its toll on poor neighborhoods, particularly in the Northeast during the late 1980s. Many middle-class Boston-area residents, for example, were looking to rent or purchase housing in the Providence area to escape prohibitive Boston

Figure 4



Source: National Low Income Housing Information Service, *Information Bulletin*, 1990.

housing costs. The result was heightened competition for housing, higher housing costs, and further displacement.

During 1987 and 1988, a frenzy of speculation wreaked havoc on the low-income housing market. Investors were selling off property, with various degrees of added improvement, at enormous profit. Many of the properties affected were converted to condominiums or high-cost rentals. Clearly the effect of speculation itself on the cost of housing, and not the housing shortage by itself, increases the rent burden of poor people and leads to displacement and homelessness.

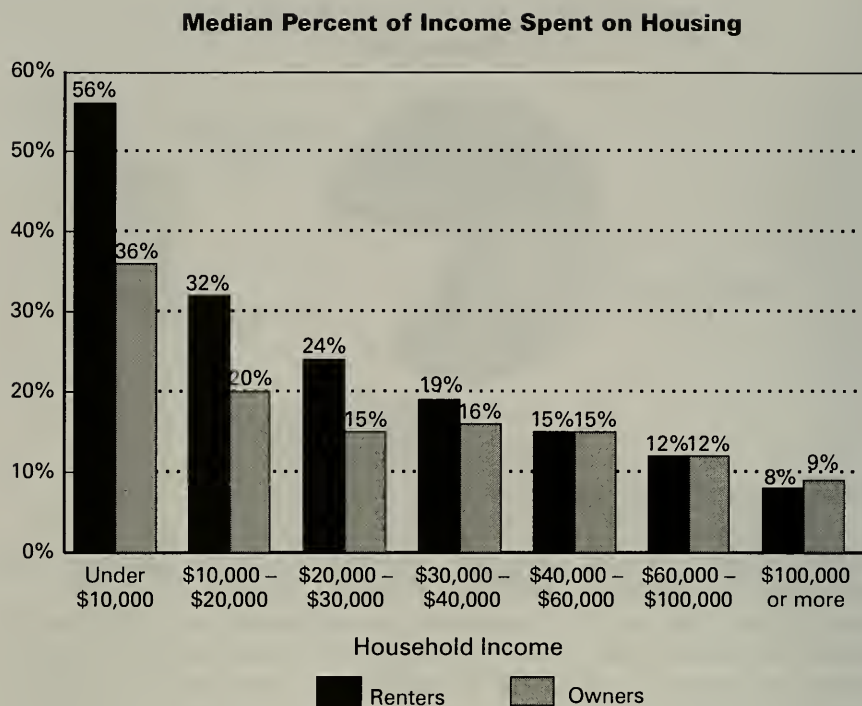
The Poor Get Poorer

In addition to, and in some ways independent of, the housing shortage and increasing rent burden on the poor, more individuals fell into poverty during the past decade, and those already impoverished suffered further decline. Even as private housing construction picked up in the late 1980s, little of it was affordable for those most in need. By 1990, there was actually a glut in high-priced housing in some regions. Thus there persists a painful gap between the cost of available housing and the ability of many in desperate need of housing to pay for it.

Today, 32 million people are living below the poverty line in the United States compared with 25 million in 1981. Of these, 12.6 million are children, representing about one child out of five. This represents a 2.2 million increase in child poverty since 1980.¹⁸ Significantly, this substantial increase in poverty occurred alongside continuous economic growth between 1982 and 1989. Not everyone suffered a decline in spending money. While the poor were worse off at the end of the decade, the wealthy enjoyed a windfall (Figure 6).

Two primary factors contributing to the increase in poverty were the recession of the early 1980s, together with changing employment requirements, and a government policy that consistently favored the well-off at the expense of the poor. For many, the recession came and then gave way to good times, but many others never recovered. One reason is that the recession dealt another strong blow to the coun-

Figure 5



From *A Place to Call Home* (1991 edition)

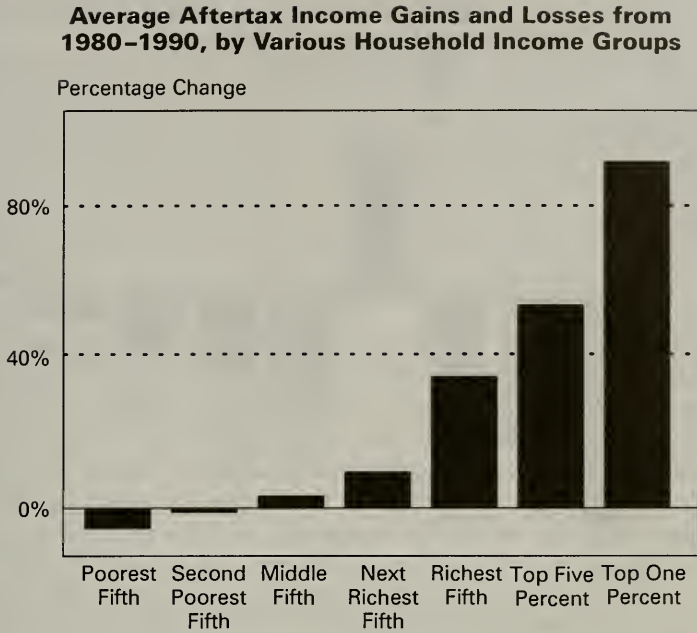
Source: *Roundup*, newsletter of the Low Income Housing Information Service, no. 146, December 1991–January 1992.

try's competitive position in manufacturing industries and the economy shifted more into high-tech and service industries, displacing workers and increasing demand for skills they didn't have. Between 1981 and 1986, approximately 2.2 million workers each year were dislocated from their jobs, according to the Bureau of Labor Statistics.¹⁹ The demand for production line work and unskilled labor never rebounded after the recession. Many workers who lost their jobs never found another one or resorted to minimum-wage employment. Many of these found themselves homeless.

In another public policy blunder, the government not only failed to compensate for this massive dislocation, it enacted policies that further impoverished the employed poor and recently unemployed. Between 1980 and 1988, for example, the real value of the minimum wage dropped by 31 percent.²⁰ In the same period, the percentage of hourly wage earners whose income was insufficient to support a family of three above the poverty line rose by more than 50 percent.²¹

As the gap between rich and poor widened, those falling into the poverty camp came increasingly from the ranks of the employed. By 1990, nearly one in four of the homeless received income from part- or full-time employment. This new category of homeless, which included families with children, elicited a response of shock and/or sympathy from much of the housed public, helping to generate attention to the crisis in the late 1980s.

Figure 6



Source: Congressional Budget Office

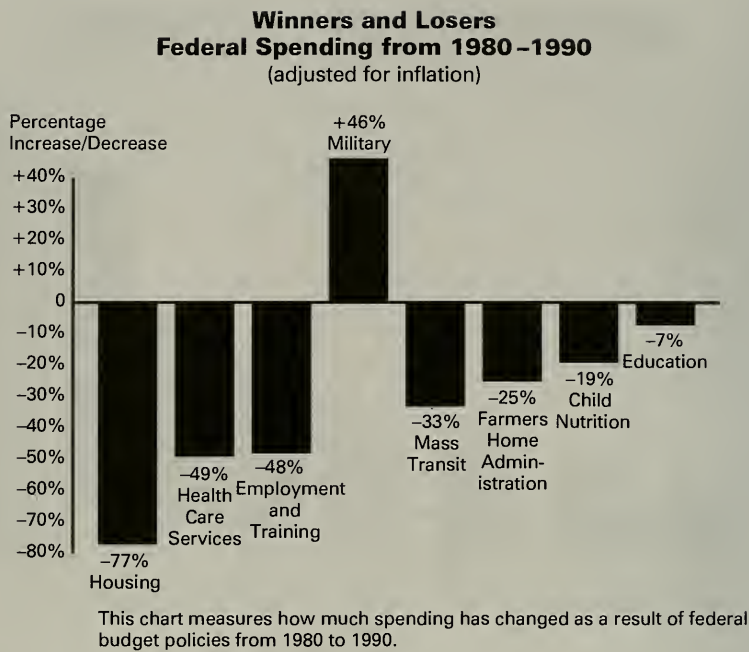
Source: National Coalition for the Homeless, *Safety Network* 9, no. 9 (September 1990).

Ronald Reagan's response to the problem was to deny that there were poor and homeless people in America and push through a series of measures that resulted in more poverty and more homeless people. Directly affecting the poor were the government's massive cutbacks in human needs programs such as housing. Federal cash payments to low-income families with children, for example, dropped by 21 percent during the decade.²² With tax, deregulation, and other policy initiatives, the Reagan administration succeeded in enriching the well-off while pumping billions into the military. The end result was a massive transfer of resources from the poor to the affluent and from human services to the Pentagon (Figure 7). When homelessness is viewed as a consequence either of a housing shortage or a household income shortage, the cause is clear: it is poverty.

The Twenty-year Solution

Various means have been employed by the federal government over the years to provide low-cost housing for the poor. One method frequently used is to offer subsidies to private developers who in exchange agree to rent the housing to low-income people at a set rate and for a specified time period (for example, thirty years). As public policy, this approach has proved flawed in many respects although it has retained its appeal among elected officials. One major weakness is that it is shortsighted. What happens when the contract expires and the private owner is permitted to convert the use of subsidized units? Contracts for many such

Figure 7



Source: Jobs with Peace Campaign, *Fact Sheet* (Boston, February 1990).

units, built in the late sixties and seventies, are now beginning to expire, opening the door for conversion and displacement. The number of units that are vulnerable to conversion in the current decade is alarmingly high. As contracts between developers and the government expire, the former are free to pay any remaining mortgage debt and change the use of their units; others will default on their loans. According to a study conducted by the National Low Income Housing Preservation Commission, without government intervention about 38 percent of all private, subsidized housing units will be lost by the year 2002 through early payment, 43 percent through default, and 19 percent will not change use. The total number of lost units will be about 523,000.²³

If this prediction becomes a reality, the effect will be a catastrophe of monumental proportions. Instead of solving the homeless problem in this decade, yet another category of people will be added to the already swelling homeless population. There are two signs of hope indicating that the unwanted effects of expiring contracts will be mitigated, though they are unlikely to be prevented entirely without radical government intervention. One sign is the current market glut for upscale housing. This, of course, is but a temporary safety valve, but at least for the moment there is little incentive in many regions of the country for owners to pay and convert their developments to condominiums or high-rent apartments. The other sign is that since the commission's study, Washington has in fact intervened. As an amendment to the National Affordable Housing Act of 1990, Congress included measures, primarily in the form of incentives, to reduce the chance that low-income housing units will be converted to other uses.

Yes, But Not in My Backyard

Although the current housing crisis stems primarily from federal policy decisions, state and local governments have also contributed to the problem. They have never been the major sources of funding for subsidized housing, a role traditionally assumed by the federal government, but they have often discouraged its development and fueled the poverty cycle by such means as exclusionary zoning ordinances and decisions and by lax enforcement of fair housing regulations. Both of these forces severely limit where poor people, especially poor minorities, can live and where low-income housing or residential support programs for homeless people or those with special needs can be located.

For example, Barrington, Rhode Island, passed an ordinance prohibiting multiple-unit dwellings (Barrington also outlawed hanging laundry on an outside clothesline!). The town of Foster requires a minimum of five acres to build a house, with no provision for cluster housing that is combined with large open space tracts. These regulations essentially exclude low-cost housing and low-income people. Similarly, the zoning hearing process is used to block low-income housing, shelters, and residential support programs. In Providence, Travelers Aid was forced to turn back a federal grant award for a runaway youth residence because the residents of the neighborhood where the program was to be located successfully pressured the zoning board to deny the needed variance. While there are legitimate reasons to deny access to a project in many cases, and neighborhoods should have some degree of control, programs are sometimes rejected on a wholesale basis, leaving them either clustered in the same (low-income) neighborhoods or without a home at all.

In addition to discouraging needed low-cost housing developments, shelter, and support programs, these actions perpetuate the ghettoization of poverty. Low-income housing projects, group homes, residential drug and alcohol programs, and shelters all wind up in the same neighborhood or in certain designated areas (for instance, Rhode Island located its emergency homeless shelter in the state's large prison complex). Ghettoization fuels the cycle of poverty, and the segregation of rich and poor people encourages the former to neglect the needs of the latter. And more poverty and neglect mean more homelessness.

Ending the Crisis: Government Responds to Pressure

When the Reagan-Bush team signaled the end of the federal government's role in meeting housing and other human needs, it expressed a philosophical conviction concerning the purpose of government. If housing and other human needs are to be responded to by the public sector at all, the view goes, the job is best left to the states and municipalities. Moreover, many feared that the administration's budget slashing would severely strain budgets at the state and local levels, thus leading to desperate attempts to mend the torn safety net. But these fears proved to be for the most part unfounded, because at the height of the nation's economic boom in 1988, many state budgets were posting comfortable surpluses. In fact, Rhode Island taxpayers were receiving token rebates from their magnanimous state government. During this period fiscal collapse was averted at the state and local levels not because the responsibilities relinquished by Washington were easily absorbed at these levels, but because little effort was made to absorb them. Now, of course, the

recession and the profligacy of the 1980s are causing enormous fiscal hardship in many states, including Rhode Island.

The homeless crisis was first recognized and responded to by ordinary citizens and private organizations. In addition to private programs aimed at getting people off the street and meeting the more urgent needs of the homeless, national and local organizations and coalitions gained momentum in pressuring for public intervention in the crisis. Of necessity perhaps, the demands brought by advocates gradually escalated from treating the conspicuous effects of homelessness to addressing the root causes. The public sector has slowly and inadequately followed along by responding to these escalating demands.

In the early 1980s, an acute and obvious need to get people off the street inspired activists to demand that state and local governments provide emergency shelter services to bridge the expansive gap left by the efforts of private groups. Gradually, public shelters began to appear. In desperation, often under court order, states and cities took to placing homeless people, particularly families, in private hotels, paying the going rate — and sometimes much more. The “welfare hotels” in New York City are probably the best known examples of this policy. The horror stories depicting conditions in some of these hotels are matched only by the insanity of the public policy decisions and procedures that created and maintained them.²⁴ Although more recently the court ordered people moved out of these hotels, New York continues to pay private hotel owners as much as \$2,300 per month to house a homeless family.

The public policy response at the state and local levels — to provide emergency shelter for the homeless — was mirrored at the federal level. Federal funds for emergency shelter became available in 1983 through the Emergency Food and Shelter Program and then again in 1987 through the Stewart McKinney Homeless Assistance Act. The latter has since been expanded beyond emergency shelter services into such areas as transitional housing, but both programs represent attempts by Congress to mitigate the effects of housing policy decisions it ratified just a few years earlier. Our elected officials found themselves in the embarrassing position of causing homelessness and trying to alleviate it at the same time. Their attempts to relieve the crisis not only skirted the real source of the problem, but the amounts appropriated for both programs were dwarfed by the large chunks taken away from housing and other human needs programs.

The citizen movement to end homelessness gained momentum through the 1980s as more and more people became aware of the vast and growing number and startling diversity of people without homes. As state authorities gradually began to accept responsibility for providing emergency shelter to keep people off the streets, advocates in larger numbers shifted their focus to some of the problem’s causes — most notably, affordable housing. The national affordable housing movement — and public concern for the homeless in general — reached its peak strength in 1989, which helped to cause a turnaround in Washington’s housing policy. The National Affordable Housing Act (NAHA) of 1990 was clearly a product of public pressure. The day before a mass demonstration in Washington on October 7, 1989, members of the House leadership met with homeless advocates and promised to push through legislation that was reduced over the following year to NAHA. President Bush thus had little choice but to pay some attention to the scandal-ridden Department of Housing and Urban Development (HUD). The scandals were embarrassing and

Bush's appointment of Jack Kemp to head the department, reestablish its credibility, and make something of it again, translated into a fresh start for housing policy.

The Bush administration, however, attempted to drag its feet, in spite of enormous public pressure, on the grounds that cleaning up HUD was all it could do for a while. This was not the time for new programs or re-funding old ones. Moreover, the "new direction" in housing favored by the administration emphasized the conversion of public housing tenants into owners rather than confronting the immediate crisis of homelessness and the acute shortage of affordable housing. In the meantime, the president answered critics by backing full funding of the McKinney Act. Although Bush's support for both homeownership and the McKinney program represent an improvement over the Reagan administration's refusal to address the housing problem, it also signifies that his own administration has not recognized in a substantive way the catastrophic effects of Reagan's failed housing policy.

Because it felt the heat of public concern a little more closely, Congress moved to revitalize the nation's housing policy. Though far from the comprehensive five-year legislative package supported by advocates, NAHA represented a small first step in reviewing the federal government's role in housing. The act incorporates the administration's Homeownership Opportunity for People Everywhere (HOPE) program and other homeownership initiatives, enhances state and local spending authority and flexibility, sets aside funding for community housing developers to build capacity, and maintains or consolidates pre-existing housing programs such as new public housing construction. NAHA also includes measures designed to prevent the loss of subsidized housing due to expiring contracts and conversions. Owners are offered financial incentives to maintain the current use of their units with a right of first refusal given to any qualified buyer willing to maintain the existing use, should the owner reject the incentives offered. This solution is costly and fails to prevent all conversions, but at least it reflects a willingness to deal with the problem.

The spending authority attached to NAHA for fiscal years 1991 and 1992 constitutes a significant increase, but just as the act was passed in the wake of mounting public activism, Washington's subsequent refusal to match the authorized amounts with actual appropriations evidently reflects what appears to be a diminishing public concern for the homeless. When the president and Congress allocated a mere \$1.3 billion in additional funds for existing housing programs in NAHA's first year (fiscal 1991), offering no money for any of the act's new programs, congressional leaders promised substantially higher appropriations for fiscal 1992. But this promise has not been fulfilled. Although the new NAMA, HOME, and HOPE programs received funding, the total appropriation in 1992 dropped from \$9.3 to \$8.8 billion. Not only is compassion and activism waning, but a conservative backlash of public hostility and intolerance has surfaced in many quarters. Follow-through on NAHA has been frustrated by Bush's insistence on funding homeownership instead of increasing the supply of low-cost housing and Congress's precarious commitment to housing as a priority. As one indicator of this declining commitment, Congress voted in the spring of 1991 to transfer \$250 million from an existing public housing program to the controversial space station project.

Underlying Policy Principles

Perhaps the solutions to homelessness offered by the federal government and many of the states thus far can be categorized as “too little too late” followed by “unkept promises.” If government intervention has yet to fulfill its share in tackling the problem, it has mitigated its effects by sheltering many people and housing a few more. But underlying public policy with respect to homelessness in this country are at least three working principles that require illumination and change. The first, best known as the trickle-down theory, that is, that accumulated wealth eventually trickles down from the few to the many, is a conscious principle of public policy. The second, tied closely to this theory, involves subsidizing private for-profit ventures to provide housing. The third principle involves waiting to address a social problem until its meanest symptoms become intolerable and then treating only those symptoms, which is a bad public policy habit.

To the extent that the trickle-down theory was ever real in the United States, wealth and benefits have not trickled down in the current situation affecting homelessness. While it is true that homelessness has historically increased during recessions and depressions in the economy and then abated, the increase in poverty over the past decade has basically defied traditional boom-and-bust cycles and therefore represents a changing dynamic. For example, our nation’s current homeless epidemic has steadily ballooned through two recessions and two periods of economic prosperity.

Focusing on the most recent years, it was the conviction of both conservatives, like Bush and Reagan, and many liberals that at least most of the poor and homeless would somehow be taken care of as prosperity and economic expansion continued to serve the better-off. Consequently, as a matter of policy, elected officials in Rhode Island chose to reap the harvest of good economic times by investing public money (from all three levels) in upscale development projects rather than in low-cost housing and other urgent community needs. For example, to attract business and improve the appearance of downtown Providence, officials went for a \$25 million project to move the river flowing through the city and create an office park. This project is half completed and the city is about to dig ground for a convention center project, also in the downtown area, having relocated the bus terminal to an inconvenient spot on the edge of town to make way. Now that the state and city are reeling from record budget deficits and a recession is upon us, these projects have lost some of their glamour and may not be completed. And it is unlikely that they will have a measurable impact on the homeless problem.

The recent boom-and-bust cycle has been particularly nefarious because rather than causing trickle-down effects, the good times seemed to drain resources from the poor, creating more poverty and homelessness. Much of the investment of the 1980s, typified by junk bond trading, was phony rather than genuinely productive, satisfying personal greed through consumption rather than human needs through the creation of jobs and housing. Trickle-down assumptions, made by government officials as a matter of ritual, were not applicable.

The second principle, subsidizing for-profit enterprises to provide housing, is a more aggressive application of the trickle-down theory. While the more conservative trickle-down policy approach depends on free-market forces to take care of social needs, the more responsive version prefers to feed private industry and investors

with public funds to facilitate the downward flow of benefits. This mode has been the predominant vehicle employed by government in housing people in recent decades. Many people, including many poor people, have been housed through this method over the years, but as a principle of public policy, it is only marginally more enlightened than the free-market approach and equally unjust.

There are many ways in which private profit is subsidized by the government to produce more housing or facilitate homeownership. But when all the housing subsidy dollars are added up, from all government programs and provisions, it should alarm the average person to find that our nation's wealthy are subsidized to a much greater degree than are poor people. A major example of this inequity is the archaic policy of allowing all homeowners to deduct property taxes and mortgage interest from their federal returns. These deductions, first provided during the Civil War, have succeeded in facilitating homeownership, but radically changed economic conditions since World War II (particularly inflation) have transformed this benefit into a windfall monster. By 1990, the federal treasury was losing an astonishing \$50 billion a year to homeowners, about five times the amount allocated to HUD for low-income housing; one third of this amount went to taxpayers with incomes exceeding \$100,000. While over 75 percent of Americans earning over \$100,000 receive federal housing assistance, only 20 percent of low-income households in the country receive housing aid of any kind, the lowest percentage of all industrial nations.²⁵ Although it retains social value for a limited purpose, the homeowner deduction can thus be seen as another contributing cause, albeit indirect, of homelessness. It has drained resources from the poor to the rich (particularly during the 1980s), encouraged homeownership at the expense of rental housing production, and contributed to dislocation and escalating housing costs as buildings are quickly traded or converted from affordable to upscale residences.

Public housing policy has also relied very heavily on private for-profit developers and mortgage credit sources to produce and maintain subsidized housing for low-income people. This widely accepted practice is defended on the ground that everyone benefits. But in weighing the relative benefits that accrue to private business and well-off individuals compared to the low-income tenant, one finds it difficult to see how poor people are the policy's intended beneficiaries. Not only does the process pay out an inordinate portion of public funds (officially intended to house low-income people), to private for-profit organizations, but reliance on profit-oriented players leads to the kind of costly bind we are now in with expiring contracts. In passing the National Affordable Housing Act, Washington found no way out of this bind other than to offer costly incentives to keep the housing affordable.

The third principle that animates much of how government responds to social crises is the tendency to respond too late and the failure to confront causes. Long-term urban renewal projects, like the Providence river relocation project, may appear to reflect long-range thinking, and when these projects are touted for the jobs they will produce and other trickle-down benefits they will create in the community, they appear to be addressing urban problems at their source. To a degree, the projects do benefit people in need by providing short-term job opportunities, but meeting the basic needs of poor people becomes a by-product of secondary, almost incidental, significance in a planning process that serves primarily wealthy investors and the mayors and governors.

More to the point is how government has refused to acknowledge the real causes of homelessness — when it concedes there is a problem at all. Typically, the response is short term, but the temporary becomes permanent, thus perpetuating the cycle in need of fundamental remedial action. Temporary emergency shelters seem to be opened as if a hurricane just blew through town and everything will be back to normal in a short while. More drug and alcohol detoxification beds are added to existing wards to handle the rising demand caused by homelessness. In Rhode Island, the largest state housing project in the past three years has been at the state prison, where overcrowding has forced the courts to levy fines against the state. One would think that a homeless person is more likely to commit a crime and take up expensive prison space than a person living in a stable, affordable home. The same is true for substance abuse. Yet at all levels of government, officials launch crusades against crime and drugs that typically rely on the courts and prisons, overlooking such obvious systemic factors as unemployment and the shortage of affordable housing. This pernicious public policy habit not only fails to address causes and thereby fails to solve chronic social problems, but it costs taxpayers a lot more money in the long run. Decent, low-cost housing is expensive, but not when compared to prisons.

Ending the Crisis: New Directions

There is a multitude of untried and underutilized remedies for the homeless crisis — many of which are creative, potentially effective, or proven — to support the conclusion that ending homelessness is a matter of political will. The recent backlash against the homeless themselves, which has led to repressive local ordinances against loitering and panhandling (even sleeping!), reflects not only intolerance, but also a frustration that we have not yet solved the problem or that the problem is hopelessly intractable. Clearly, the collective “we” have not adequately resolved the crisis, giving rise to a well-grounded frustration, but the elimination of homelessness is within our reach if we are willing to change our collective priorities. I am convinced, therefore, that the challenge of eliminating homelessness is primarily one of generating enough political will. Indeed, the way is open and the choices are many.

The foregoing analysis suggests that many policy changes are needed, but overall, attention needs to be paid to three broad and overlapping categories: housing, support services, and unemployment and poverty. To end homelessness, the public must see to it that a sufficient amount of decent, stable, affordable housing is made available, that adequate support services are provided for homeless persons while they are homeless, in transition, and in permanent housing, and that poverty and unemployment are eliminated.

Housing the Homeless

Therefore, in my view, a new federal housing policy that intends to eliminate homelessness must include these components.

1. Housing should be regarded as a right, much as it is in many industrialized and developing countries throughout the world. Housing programs should be entitlement programs.

2. This means a substantial increase in public funds, particularly at the federal level. An indication of the minimum commitment required is reflected in the Mickey Leland Housing bill introduced, but not passed, in 1990. This measure authorized an expenditure of \$125 billion over a five-year period. The principal source of new housing funds would likely be the military; such a transfer of funds would also yield more employment if weapons programs were targeted for cuts.²⁶ The savings and loan and bank bailout programs should also increase affordable housing by selling off residential assets to housing nonprofits at discounted rates. Finally, billions could be devoted to low-cost housing if homeowner tax deductions are curtailed.

3. The for-profit sector, as it participates in housing production at all levels (credit, development, management, ownership, and so on) should be more tightly regulated to increase the availability of affordable housing.

4. Beyond these regulatory measures, which have immediate application, the most important long-term goal should be the transfer of ownership and control over low-income housing from the private for-profit sector to the communities in which the housing is located (social control). For example, a community may be represented by a nonprofit land trust or housing developer, a limited equity cooperative, or the state or local government. Social ownership and control can take many forms and does not necessarily mean government ownership and control. Two promising vehicles that have become increasingly available to apply social control at the local level and outside of government are nonprofit housing groups and community land trusts. Both are private, operate on the energy of people in the community who want to see land and housing used for the common good, are monitored by government regulations, and earn no profit. First, it will permit a more efficient use of public funds intended for those in need by minimizing the cost of private profit in the housing production and management process. Second, social control will stabilize housing for those who are currently vulnerable to landlord action and displacement that appears arbitrary. Third, social control will allow for continuous affordability because affordability rather than market opportunity is the prime criterion for transferring ownership on use of housing units. Fourth, it represents a clear alternative to the principle of might — or wealth — makes right in determining the distribution of such necessities as housing.

5. Developing and managing subsidized housing should be decentralized. Creative, local housing solutions, including multisector partnerships, land trusts, and cooperatives, have emerged as coping devices during this period of scarce federal funding. This approach should be continued and encouraged. Federal funding can most effectively take the form of direct one-time grants that pay for property acquisition and construction/rehabilitation, permitting nonprofit developers to operate debt free and apply rents to maintenance expenses alone.

6. Fair housing is as important as more housing in combating racism, poverty, and homelessness. Low-income people, especially minorities, do not enjoy the freedom either to remain where they are living or to move where they want to move to the extent other people do. Nationwide investigations continue to reveal that African-Americans and Hispanics seeking to rent or purchase homes in predominantly white neighborhoods are subject to discriminatory treatment about 50 percent of the time. Fair housing requires strict enforcement and strengthening of the Fair Housing Act of 1968 and other existing legislation and that each community — and city neighborhood — share in the provision of affordable housing and support programs.

More Than a Home: Support Services

If this country were to reach the goal of providing every person in need with a safe, decent, stable, and affordable home, it would be a great achievement. But this would not in and of itself end homelessness; it would only substantially reduce it. Illnesses such as schizophrenia, drug addiction, and pathological violence, or simple deficiencies in education and health care still make it difficult or impossible for some to keep their housing. Moreover, because homelessness has a damaging effect on a person, and on family units, support services are essential for people who have become homeless if they are to keep their housing. The longer they are left on the street and in shelters, and the more people who become homeless, the more support services will be needed to repair the damage.

In considering what services to offer and how to offer them, policymakers should apply these two principles: because homelessness is basically a housing issue, services should be provided in conjunction with housing, and services, publicly and privately offered, should be vigilantly coordinated, probably by state or city human service departments, to minimize duplication and assure continuity of care.

Adequately serving the needs of the severely mentally ill is a major challenge. Past mistakes, almost universally acknowledged, still need to be corrected. We need more residential care homes — group homes that provide close personal and medical supervision and care, homes that provide lay supervision in conjunction with CMHC outpatient services. We also need more opportunities for visiting care available for those stable enough to live in independent housing. Although most of the homeless mentally ill can be cared for by these arrangements, more flexibility is needed to hospitalize involuntarily those who are very sick and not meeting their survival needs in the community.

Drug and alcohol abuse are equally challenging problems. The “war on drugs” must be urgently redirected toward education, treatment, and the cessation of imported drugs. Particularly, additional beds are needed for residential detoxification, treatment, and halfway support.

Finally, we need to provide a wide array of services tied to housing projects in addition to mental health and substance-abuse treatment. These services might include family counseling, group and individual therapy addressing domestic violence, job counseling, day care, nutrition, health and home skills education, and case management. Many of these services should be available on site, especially in larger housing projects and developments.

Homelessness seems like an intractable problem, leading many to conclude that it has become a permanent feature of our society. If homelessness poses a major challenge to public policymakers, which it does, it will be a bit easier to handle, at least at the superficial level of getting everyone into a house, than will the older and larger problem of poverty that feeds homelessness. In turn, poverty is both a cause and effect of alienation and marginalization, which are deep seated and have historical roots. The articulation of a new public policy must incorporate an understanding of this to effectively address the root causes of homelessness.

The process of forging this policy has begun spontaneously at the grassroots level. Progress is made whenever a tenant group buys or acquires management control over their development or when a housing nonprofit acquires a city parcel with a

house, places the parcel under a land trust, and converts the house to a limited-equity cooperative. These are probably the most real and hopeful signs of positive change. Yet public policy change requires a broader-based movement at the local and national levels. Elected officials are often the last to adopt the kinds of proposals outlined here. Moreover, until there is new leadership in Washington, any progress will be slow and frustrating.

A movement for change requires the education and political mobilization of ordinary people to generate the political will needed to affect policy. While the growing diversity of the homeless population has inspired many to respond compassionately and participate in public demonstrations for housing, advocates must educate these supporters to go beyond the myth of the deserving poor. This attitude, fed by the media, sets up a class system among the poor and homeless that ignores the common roots of all poverty and homelessness.

As pressure for change trickles up to policymakers in Washington, what is called for here is clearly something on the scale of a Marshall Plan, a scale of change that will inevitably cost a degree of disruption for many. As it stands, I fear we can count on a measure of upheaval ahead of us if we choose to stay the current policy course. Even without upheaval, the status quo policy has proved to be a failure, with mass homelessness, crime and violence, poverty, and drug abuse providing some of the most conspicuous evidence. It is not working, and a fundamental departure is urgently needed. 🐼

Notes

1. Jonathan Kozol, *Rachel and Her Children* (New York: Crown, 1988), 30.
2. *Ibid.*, 76.
3. For a report and commentary on the Census Bureau's controversial count of the homeless, see *Safety Network*, a newsletter of the National Coalition for the Homeless, no. 5 (Washington, D.C., May/June 1991).
4. Figures are based on a survey conducted in twenty-eight cities across the country. U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1990* (Washington, D.C., 1990).
5. *Ibid.*
6. Rhode Island Emergency Food and Shelter Board, "The Rhode Island Emergency Shelter Information Project — Phase II" (Providence: United Way of Southeastern New England, June 30, 1990), 7.
7. National Coalition for the Homeless, *Safety Network*, no. 4 (April 1991): 2.
8. Cushing Dolbeare, "Out of Reach" (Washington, D.C.: Low Income Housing Information Service, 1989).
9. Fuller Torrey, *Nowhere to Go* (New York: Harper & Row, 1988), 140, 219–20. Torrey's book provides a critical, comprehensive analysis of deinstitutionalization and the resulting problem of the homeless mentally ill.
10. In addition to Torrey's critique, a more recent report published by the National Institute of Mental Health (a federal agency created in 1946 to facilitate and otherwise improve the provision of mental health services nationwide) includes many of the criticisms of deinstitutionalization mentioned here. "Deinstitutionalization Policy and Homelessness" (Washington, D.C.: NIMH, May 1990).

11. U.S. Conference of Mayors, *A Status Report*.
12. American Institute of Architects, "Housing the Homeless," conference proceedings, 1985, 10.
13. U.S. Conference of Mayors, *The Continued Growth of Hunger, Homelessness, and Poverty in America's Cities in 1986* (Washington, D.C., 1986).
14. Rhode Island Emergency Shelter Information Project, "Interim Report on Homelessness in Rhode Island," January 1991.
15. Kozol, *Rachel and Her Children*, 12.
16. Homelessness Information Exchange, *Homewords* 3, no. 4 (Washington, D.C., April 1991).
17. Rhode Island Housing and Mortgage Finance Corporation, "Comprehensive Housing Affordability Strategy," preliminary draft (Providence, 1991), 8.
18. Children's Defense Fund, "Children in Poverty" (Washington, D.C., June 1991).
19. Bureau of Labor Statistics, cited in *Homewords*.
20. See *Homewords*.
21. Children's Defense Fund, "Children in Poverty."
22. Ibid.
23. National Low Income Housing Preservation Commission, "Preventing the Disappearance of Low Income Housing" (Washington, D.C., 1988), 43.
24. Kozol's *Rachel and Her Children* offers a graphic critique of the New York welfare hotel system.
25. Peter Dreier and John Atlas, "Defund the Mansions," reprinted in the *Providence Journal*, May 18, 1991. A good case in favor of reforming the current tax policy is also made by Cushing Dolbeare in "The Low-income Housing Crisis," in *America's Housing Crisis*, Chester Hartman, ed. (Boston: Routledge & Kegan, 1983), 60–75.
26. Weapons programs are relatively poor job producers. According to a 1976 Bureau of Labor Statistics study, a billion dollars invested in defense industries generates approximately 75,000 jobs compared to 100,000 jobs in construction, 138,000 in health care, and 187,000 in education. Cited by the Boston Study Group in *The Price of Defense* (New York: New York Times Books, 1979), 293.

Framing and Claiming the Homelessness Problem

David A. Rochefort
Roger W. Cobb

Despite a recent upsurge of interest in the issue, homelessness is a problem of long standing in American society. This article traces how several forces catalyzed the problem's re-entrance onto the political agenda in the 1980s. It then reviews the ongoing debate over homelessness causes and cures as a struggle for problem ownership that has complicated the choices of public policymakers. The final section examines various descriptive attributes that figure into the dispute over how to define homelessness and influence the nature of the public policy response to it.

The lack of a place to live must surely rank as one of the most devastating human experiences in modern society. Forced to choose between the perils and indignities of the street and inadequate public facilities, the homeless find themselves separated from the mainstream community. From this precarious station all attempts to maintain the activities of a "normal" existence — locating and keeping employment, fulfilling family responsibilities, protecting one's own physical and mental well-being — become extraordinary challenges. Even the receipt of welfare checks, itself a symbol of marginality, is more problematic for those who have no address. Compounding the situation are the complex, ambivalent reactions of fear, hostility, disgust, pity, compassion, and guilt with which the homeless are viewed by more fortunate members of society.¹

Academic study of the homeless and their plight has grown by leaps and bounds over the past decade. Demographers and survey researchers have counted the homeless, analyzing their composition and geographic distribution. Sociologists have determined the conditions of existence of the homeless and the sequence of events bringing them to misfortune. Health care professionals have assessed their physical and mental states. Social workers have looked into the varied adjustment issues facing homeless families and the shortcomings of current support services. Arguably the most important question of all, however, has yet to receive an ade-

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quate answer: What accounts for the limited, disorganized, and ineffective way in which public policy has responded to this pressing social issue?

The purpose of this article is to provide further information and insight relevant to this puzzle. It argues that development of homelessness public policy has been hampered by fundamental disagreements over the nature and causes of the problem being addressed. Guiding this analysis is a "problem definition" framework that emphasizes the malleable quality of public issues, that is, their openness to competing factual interpretations and value stances.² The ongoing struggle over how to define homelessness as a public problem — one in which diverse outlooks, interests, and philosophies shape the positions of different actors — enriches the policymaking dynamic but also diffuses it by producing confusion over the promise and very appropriateness of proposed interventions.

If public problems are not simply "givens" but are matters of interpretation and definition,³ it is necessary, first of all, to explain how homelessness gained recognition as a serious public concern during the 1980s. Next we review the debate over homelessness causes and cures as a conflict over "problem ownership." Finally, we consider a set of definitional issues having special import for homelessness policy that are raised by this debate and cut across it.

How Did Homelessness Enter the Political Agenda?

The attention capabilities of government are necessarily limited. There are always more matters vying for the notice of decision makers than can be actively considered. Agenda building refers to the process through which problems or issues come to command the active and serious attention of government officials as prospective matters of public policy. Two separate agendas are of crucial importance: the public agenda and the formal agenda. The public agenda consists of those issues that a sizable portion of the population believe merit government attention. The formal agenda consists of those items up for serious consideration by officials in one or more units of government (for example, legislatures, courts). The size of the public agenda is limited by the public's interest in any given set of issues, that of the formal agenda by time and resource constraints.

Since many matters are "givens" on a formal agenda (like budgetary matters or previous issues, such as abortion, that remained unfinished in past considerations by officials), there is very little space for new items. Indeed, officials could devote all their time to focusing solely on old issues. Yet new issues inevitably emerge. How? One source of new items on the formal agenda is those issues which spill over from the public agenda. Popular concern about an issue normally means that officials will give it consideration. However, the public agenda is much more volatile than the formal agenda. The public's attention span is more limited than that of officials, and members of the public often have to be stimulated by external sources to follow a problem.⁴

Keys to Issue Visibility

Since public agenda access normally precedes formal agenda consideration, what enables an issue to attain sufficient visibility for the public to recognize that a problem exists? First, there needs to be a change in the external appearance of a problem. Regardless of how serious the consequences of an issue are, there needs to be a sudden and dramatic increase in awareness of a problem's existence. For example,

oil tanker safety has long been a concern for environmentalists. But until the *Exxon Valdez* crashed off the coast of Alaska and spilled thousands of gallons of crude oil into Prince William Sound, threatening fish and fowl, beaches, and other aspects of the natural habitat, people did not take the issue to heart. At that point, however, the issue quickly appeared on the public agenda.⁵

Second, there needs to be media interest. This can come from the occurrence of an event such as the leaking of the *Exxon Valdez*, or it can come from the media's new attention to a problem that has always existed. An excellent example is the media's discovery of the hunger problem in Ethiopia in the mid-1980s. People had been starving there as a consequence of a civil war and drought for a number of years, but a documentary sponsored by the BBC and run on NBC caused an intense interest in the issue, which ultimately led to Ronald Reagan's administration sending food aid to a Marxist government that was anathema to it. Rock concerts by popular singers also raised millions of dollars to feed the hungry. Significantly, after the passage of some months, interest waned even though the problem did not.⁶

A third component of public agenda access is the existence of activists on behalf of a cause. For years, health groups and the American Cancer Society have been working for tougher regulation of the tobacco industry. These antismoking actors are taking on a formidable economic interest and, until recently, their victories have been few and far between, despite diligence on a variety of fronts: law suits, new legislation, commercials on television discouraging smoking, and the creation of the issue of passive smoking. What has proved equally important, however, is the appearance of an individual who has skill in using the media and is an articulate spokesperson for the cause. Under the Reagan administration, Surgeon General Everett Koop became this leader pushing for additional controls on the tobacco industry. He raised public consciousness concerning the issue, and smoking rates declined during this period.⁷

Homelessness as a Public Issue

How does the agenda-building concept relate to the problem of homelessness? The first question to be asked: Is homelessness a new issue or merely an old issue newly named? The preponderance of evidence points to the latter position. The main thing that is "new" about homelessness is the level of attention it now receives. It has been a concern as far back as Colonial America. New England towns created residency requirements for dealing with the problem. Those with "settlement rights" were accepted as members of the community; those who were not (typically transients) were neither accepted nor helped.⁸

The number of homeless increased dramatically in nineteenth-century America. The westward movement, industrialization, and the rise of urban centers all required a large manpower pool provided mainly by immigrant workers. Such individuals were needed to provide seasonal and episodic labor. In addition, a series of major economic dislocations left many jobless and homeless. The problem became a real concern of local police departments, which jailed such people on charges of vagrancy. Toward the end of the century, the homeless settled in dilapidated parts of the city, known as skid rows, which meant the centralization and isolation of those without a place to live. The beginning of the twentieth century also brought a decline in the demand for transient unskilled labor and left many men without a job.⁹

Local homelessness increased dramatically in the depression of the 1930s. Most of the dispossessed did not elicit great public sympathy, with the partial exception of families in the dust bowl states who lost their farms and were forced to move to the West. Shantytowns grew in many cities, and large numbers of men became unemployed for long periods of time. This population was reduced but not eliminated by the post-World War II prosperity. Urban renewal programs displaced many of the shantytowns, but the homeless simply moved to other declining areas in the city. As a result, the problem was constantly festering.¹⁰

Homelessness in the 1980s

A combination of elements brought the homeless to the public agenda in the early 1980s. First was the involvement of a number of activists. A New York City attorney who later founded the National Coalition for the Homeless, Robert Hayes, filed a legal action on behalf of vagrants in the Bowery section in the late 1970s. This suit led to a decree requiring the city to provide shelter for all homeless people who sought it. A group of demonstrators protested at the 1980 Democratic National Convention in New York City, demanding better conditions for the homeless.¹¹ A series of books also came out in 1981 focusing on the issue, including such titles as *Shopping Bag Ladies*¹² and *Private Lives/Public Spaces*.¹³

An especially bitter winter in 1981–1982 led the media to focus on grim stories of people freezing to death in cities throughout America.¹⁴ This led to a second ingredient promoting agenda access, media interest. Stories of people facing death and despair are a staple of television news. With most Americans receiving their news primarily through television reports, it is not surprising that a 1989 *New York Times* poll reported that half of all Americans found out about the problem of homelessness by watching television (the other half had seen the problem in person).¹⁵ Another important stimulus for increasing media attention to the homeless at this time was political controversy over social welfare cuts in the first Reagan administration and their impact on society.

Third, an issue entrepreneur was the catalyst who helped bring many of these elements together. Mitch Snyder, a longtime activist in the antiwar movement in the 1960s and early 1970s, participated in creating the Community for Creative Non-Violence in Washington, D.C., in 1970. The group started out protesting the war in Asia, but by the late 1970s it had turned to the homeless as its major concern. Snyder was a committed idealist who knew how to develop media events galvanizing public attention. In 1984 he staged a hunger strike that lasted fifty-one days with constant publicity. He finally extracted a promise that federal money would be used to renovate the largest homeless center in the nation's capital before ending his fast. In 1986, Snyder brought congressional members and Hollywood stars out to sleep in the streets of Washington, D.C., for one night, which was dubbed "the Grate American Sleepout." All these participants were adept at dealing with the media themselves and helped to publicize the issue. Snyder staged other "sleepouts" in front of national monuments for various lengths of time during all seasons to keep the public's attention.¹⁶ A speaker at a Boston rally held in July 1991 to commemorate the first anniversary of Snyder's death stressed his unique contribution to the homelessness cause: "Without Mitch, who will shoulder the burden? Who will take Mitch's place? Who will carry the anger and joy that Mitch carried? Who will fast and who will pray? Who will show his anger and go to jail? And who will stand up before the powers that be and tell the truth?"¹⁷

Fourth, Stern notes that the homeless became pawns in larger battles for power between different levels of government. In New York City in 1980, for example, Mayor Edward Koch resisted state pressure to open more shelters because he felt the city could not afford them. Public clamor for action ensued. Koch thought his deliberate inactivity would prod the state into taking responsibility for the homeless. Thus, this group became a political football as different agencies tried to avoid the responsibility for dealing with the problem, thereby making their short-term plight worse but inevitably raising their visibility.¹⁸

Fifth, there was a change in the attitude of police toward the homeless. In the past century, police "sweeps" would clear certain areas, with the people being jailed or moved. Now that the homeless had become so many and with the decriminalization of many minor offenses, police devoted their limited resources to dealing with more serious problems, such as drugs and physical assaults.¹⁹

Sixth, although homelessness is not a new problem in American society, its form has evolved in a way that brought it into prominence in the 1980s. Previously the homeless were confined to rundown areas or skid rows where people did not have to see them. By the 1980s, the numbers had increased and the families moved into the central business areas of cities. That meant more middle- and upper-class citizens would be forced to witness homelessness and, in some situations, confront homeless individuals. The problem could no longer be ignored. In previous times, the homeless were likely to be men; now one could find women and families without a place to live.²⁰ Finally, the decade of the 1980s was one which saw a vast accumulation and display of wealth.²¹ In this context, homelessness stood out because of its contrast with the trend of economic affluence.

Homelessness as a Fluctuating Issue

The homeless, then, have always been a social problem, although not one consistently receiving the attention of public policymakers or the general citizenry. Recently, however, they have managed to attain the volatile public agenda and have squeezed onto the formal agenda for consideration. Yet, it should be noted, they are not a permanent resident on either agenda. Interest in their plight is spasmodic, depending on such factors as seasonal weather shifts and the ascendance of competing social issues. As demonstrated in Figure 1, the priority given by the public to the homeless waxed and waned repeatedly just over the past five years.²² There is no reason to believe this pattern will be altered in the future.

Claiming "Ownership" of the Homelessness Problem

Central to the definition of public problems is their "ownership."²³ To claim ownership of a problem is to seek control over how it is thought of and acted on within the public arena. What causes a problem, who is most directly affected and how, and which remedial approach will have the most effect are all controversial questions in the typical public policy debate.²⁴ Out of the political cacophony of contending opinions and factual assertions, the problem's owner is the one who comes to speak with recognized authority and shapes the direction of public intervention from among many conceivable alternatives.

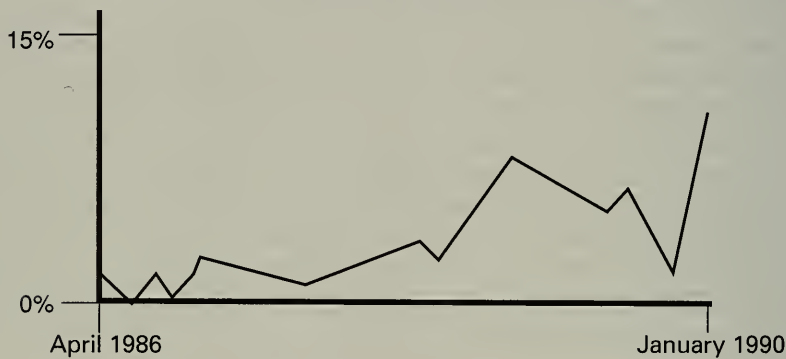
Problem ownership may be claimed by an individual (such as an academic expert) or by a group that has coalesced to promote some professional, disciplinary, religious,

economic, or ideological interest. Incentives for engaging in the ownership struggle are several, can vary according to the actor involved, and are not mutually exclusive. An obvious motivating force for those claiming problem ownership in order to gain added resources, territory, or prestige is self-interest. But another purpose may be to promote an impartially researched and reasoned assessment of an important public issue. Ownership claims may also be advanced as an unconscious reflexive expression of the identity, values, and intellectual outlook of the claimer.

Figure 1

Changing Public Agenda Status of the Homeless

"What do you think is the most important problem facing the country today?" Line shows percentage of adults who responded "homelessness."



Source: Based on fourteen *New York Times*/CBS News Polls and one *New York Times* poll.

Yet how is it that so many competing perspectives are possible on a single public issue, one which has captured widespread attention yielding abundant factual information? The answer lies in the inherent causal complexity of social reality. In the language of social science, every public problem results from multiple "independent variables." These variables exert their influence simultaneously, as part of sequential chains, and as greater or lesser components of hierarchical structures. Varying problem definitions arise from the way that different observers interpret the available data within this framework of analytical possibilities and from the relative importance they assign to the identified causal factors.

These general observations provide a key to understanding the dynamic quality of the homelessness debate, in which housing, economic, and mental health advocates continue to vie for centrality. We will also consider a "holistic" definition of the problem that attempts to incorporate multiple causal factors and corrective measures.

Homelessness as a Housing Problem

Taken most literally and immediately, homelessness is the lack of a suitable residence. Eschewing distracting complications, some policy analysts and activists adopt this narrow focus for explaining the occurrence of homelessness. For example, Jonathan Kozol, best-selling author of *Rachel and Her Children*, selects families as the most significant part of the homelessness problem and gives this response to the question of why they are without homes.

Unreflective answers might retreat to explanations with which readers are familiar: “family breakdown,” “drugs,” “culture of poverty,” “teen pregnancies,” “the underclass,” etc. While these are precipitating factors for some people, they are not the cause of homelessness. *The cause of homelessness is lack of housing.* [Emphasis in original]²⁵

Another author notes the different forms and degrees of homelessness that exist according to the time period involved (temporary, periodic, chronic, and total) and the type of persons affected (single men and women, poor elderly, ex-offenders, single-parent households, runaway youths, substance abusers, and ex-psychiatric patients). Underlying most variations, she concludes, is one basic element, “the critical shortage of low-cost housing.”²⁶ Maria Foscarnis, an advocate with the National Coalition for the Homeless, is another who has put the matter very bluntly: “Homelessness is primarily a housing problem to be addressed with more housing.”²⁷

Compelling statistics are available to underscore this perspective.²⁸ Each year, fires, demolitions, and conversion upgrades eliminate approximately 500,000 low-income housing units. Federal funding for publicly owned and assisted housing declined by about 80 percent over the last decade, with a consequent sharp fall in federal housing starts (to 20,000 in 1989 from 183,000 in 1980). Vacancy rates as low as 2 or 3 percent indicate the tightness of the housing market in major cities like New York and Boston. Meanwhile, fewer and fewer low-income persons can hope to realize the American dream of homeownership, as mortgage payments on new homes demand an ever rising portion of household resources.

Prescribed remedies follow logically from the diagnosis of ills — a host of different housing arrangements targeted to those in need. Or, as Robert Hayes of the National Coalition for the Homeless has stressed, solving the homelessness problem requires “housing, housing, housing.”²⁹ Development of an adequate shelter system is a front-line, stopgap measure. Also necessary are more comprehensive policy reforms meant to replenish the dwindling low-income housing stock.

This housing definition of the homelessness problem proves flexible enough to fit both liberal and conservative philosophies. On the liberal side, the approach of choice is a large-scale infusion of public funds, primarily from the federal government.³⁰ Some activists have even pressed the courts to recognize a constitutional “right to shelter” compelling public authorities to provide housing to the homeless as a legal entitlement, although this strategy has been largely unsuccessful to date.³¹ One conservative solution is to deregulate the housing market on the local level through weakened housing code enforcement and the elimination of rent control, thereby protecting low-rung housing from extinction and stimulating new rental housing development.³²

Homelessness as an Economic Problem

For some observers of the homelessness problem, the shortage of affordable housing in the United States raises more questions than it answers. Why is available housing so expensive? Why aren’t incomes sufficient to allow people to purchase on the present market the housing that they need? Concentration on these issues leads to a definition of homelessness that is economic in orientation.

One review of studies of the homeless in a number of major urban centers revealed the following economic facts: many homeless persons had no jobs or income whatsoever and most others were underemployed; there was a high dependence on government transfers; most of the homeless stated that they would work if they

could get a job; and they most often cited economic reasons when asked to account for their situation. The reviewer analyzed these data as follows:

Evidence from local studies, testimony before congressional committees and other local reports indicates that service providers and advocates alike agree that economic conditions constitute the primary underlying cause of most homelessness. Despite the many pathways that lead to the loss of shelter, all slope down the incline of economic hardship. Economic weakness makes coping with illnesses, handicaps and addiction seriously debilitating, especially when someone has no place to stay that they can afford. The wealthy or the well-insured, although they may endure similar illnesses, handicaps or addictions, avoid the privations of the streets and the indignities of dependence by purchasing the care their savings or insurance benefits afford them.³³

Peter Rossi, one of the nation's leading social researchers on the subject, takes a similar economic position when he holds that "homelessness is more properly viewed as the most aggravated state of a more prevalent problem, extreme poverty."³⁴ When the American Public Welfare Association (APWA) formulated a special policy statement on the nation's housing problems, its first recommendation spoke to the issue of comprehensive welfare reform and the need to improve cash benefits so that needy families could afford their shelter costs. Emphasized the APWA, "The welfare system has become the housing agency of last resort for the poor."³⁵ According to at least one national survey in the late 1980s, it is the economic perspective that best parallels the view of a majority of citizens, who said that a lack of jobs or a poor economy is the main cause of homelessness.³⁶

The ultimate culprits in this kind of economic analysis are the macroeconomic forces that produce destitution and inequality in our society. Hopper et al., for example, argue that "widespread homelessness in major urban areas in the 1980s must be related to wholesale changes in the political economy of the city. Deindustrialization, or the shift from manufacturing to the finance and service sectors, with its accompanying 'renovation' of the central business district and surrounding areas in the inner city, is the driving force behind the process."³⁷ Belcher and Singer speak even more broadly of homelessness as a "cost of capitalism."³⁸ Among the specific factors they cite as responsible for homelessness are business mergers and corporate takeovers that have thrown workers out of jobs; the movement of U.S. businesses to foreign countries; and anti-inflationary policies of the early Reagan years that led to recession and high unemployment. They and others also emphasize the negative impact of cuts in public welfare, disability support, and other social programs during the 1980s.

The program of reform that stems from such sundry economic analyses contains many possible initiatives, some of them verging on the visionary. One proposal related specifically to housing policy is the so-called fair share/balanced housing plan. As Lang explains, "Most low cost housing programs are place-oriented and seek to reestablish and refurbish the ghetto. Those programs are doomed to failure since many of the rehoused will soon be homeless again due to the lack of an economically viable and supportive local community."³⁹ Accordingly, the recommendation is that suburban communities, where much of the new job growth is located, no longer be permitted to utilize exclusionary zoning to keep out multifamily and other forms of low-cost housing. Moreover, these communities would also be required to provide decent housing for a "fair share" of the area's poor. Some noteworthy inclusionary zoning programs have been implemented in New Jersey, Massachusetts, and California.⁴⁰

The purpose of certain other proposed policies, such as a national full employment/minimum income program, would be to assure that the poor have adequate resources to pay for their housing.⁴¹ Income redistribution, it has been suggested, could provide a means for financing the effort. Finally, some proponents argue that government could undertake tougher regulation and taxation of the activities of private business to safeguard the well-being of the most vulnerable.

Homelessness as a Mental Health Problem

No single population group has come to be associated more strongly with homelessness than the mentally ill. The comment of one group of homelessness researchers that “common folk wisdom remains hostage to the notion that were it not for the mentally ill, there would be no crisis of homelessness”⁴² is an exaggeration, but it contains an element of truth. Mental health advocates generally do not deny the heterogeneity of the homeless population or the desirability of an appropriately diversified governmental response, yet their emphasis is unmistakable. In the words of psychiatrist E. Fuller Torrey, “The seriously mentally ill are the most poignant and helpless of the homeless population.”⁴³

Interpretation of homelessness as a mental health problem derives in large part from the collection of statistics on the number of homeless people with psychiatric impairments.⁴⁴ Typical estimates fall in the neighborhood of 30–40 percent, although some studies have placed the figure as high as 90 percent. Statistics on the average mental illness rates of designated subgroups of the homeless, such as women and the out-of-shelter street people, tend to be even higher than for the homeless overall. Another substantial segment of the homeless, again perhaps as much as one-third, are identified as having substance-abuse problems, also a condition commonly “claimed” by the mental health community. Add to these data the number of homeless persons judged to be at risk of developing emotional difficulties because of the stressful experience of homelessness — young children are a prime example — and you have a compelling depiction of the entanglement of mental health and homelessness issues.

Disenchantment with the controversial policy of deinstitutionalization is the second main component of the homelessness/mental health construction.⁴⁵ This theme stresses that the emptying out of public mental hospitals since the mid-1950s (from a high of 559,000 patients to fewer than 110,000 today), coupled with the current practice of community-based care, is the responsible agent behind our vast numbers of homeless mentally ill.⁴⁶ New York senator Daniel Moynihan expressed this view in a letter to the editor of the *New York Times*. The failure of deinstitutionalization, he wrote, “is precisely where to begin any discussion of the homeless.”⁴⁷ Firing off a salvo at deinstitutionalization advocates, a hospital medical director attributed blame to the same source.

Some supporters of deinstitutionalization are aware of the plight of the mentally ill in the community, but instead of faulting deinstitutionalization, they condemn society for not doing more to make life livable for the chronically ill in the community. These supporters are so committed to deinstitutionalization that they do not criticize those who let the fox loose in the chicken coop but rather those who do not give the chickens adequate protection.⁴⁸

Others in the psychiatric community, like Torrey, draw a careful distinction between the concept of deinstitutionalization and its faulty implementation, concentrating their complaints on the latter.

For those who link homelessness so tightly to mental health concerns, what, then, is the means for rectifying the problem? A range of opinion exists, although on one point there is consensus: housing and jobs — the principal plans of action, respectively, of housing and economic advocates — are not enough to address the special needs of the mentally ill. Militant opponents of deinstitutionalization call for such measures as restoring the state hospital system and easier commitment procedures. Proponents of a comprehensive, adequately funded community mental health system propose a spectrum of supportive services.⁴⁹ A task force report of the American Psychiatric Association on the homeless mentally ill lists fourteen recommendations, including more supervised housing, crisis intervention services, case management, and treatment and rehabilitation.⁵⁰

Homelessness as a Holistic Problem

The housing, economic, and mental health definitions of homelessness are derived from placing emphasis on a particular segment of the homeless population or on a particular grouping of causes and interventions. A last major contending definition of homelessness moves in just the opposite direction. It promotes as inclusive a view as possible along all these dimensions. Thus it is holistic in nature, aiming to take account of the analyses of virtually all major participants in the homelessness discussion and to marry their divergent policy recommendations.⁵¹

Certain key terms and ideas are central to the holistic perspective on homelessness. The problem is viewed as being complex, heterogeneous, and multifaceted. Solutions should be comprehensive, broadly based, and integrated. A representative policy product of this approach is the Stewart B. McKinney Homeless Assistance Act of 1987 (Public Law 100-77), which encompasses as many as eighteen programs.⁵² Both new homelessness initiatives and increased funding for existing programs are included to better serve the homeless in such disparate areas as emergency food and shelter, supportive housing, health services, rent subsidies, community mental health services, adult literacy, and veterans job training.

The very nonexclusivity of a holistic definition of social problems makes it appealing on intellectual and political grounds. To social scientists and other policy researchers, it may suggest a probing, coherent overview that doesn't oversimplify an issue just to make it seem more manageable. To elected officials, it offers a means to satisfy pluralistic demands by distributing resources among many interested parties. Yet holistic policy actions are perhaps intrinsically ill fated due to their reliance on complicated, coordinated implementation and funding systems, dispersion of effort, problems of scale, and the often rapid erosion of their ad hoc base of political and popular support.⁵³ Significantly, in the years since its passage, appropriated funds under the multi-pronged McKinney Act have fallen far below the legal authorization.

Other Definitional Elements

Our review of the debate over ownership revealed fundamentally differing perceptions about the nature of homelessness. We turn now to four additional descriptive attributes that figure into the public dispute over homelessness and powerfully condition policy responses to the problem.

The Magnitude of Homelessness

An essential determinant of a public problem's perceived importance is its scope, or the number of people affected. The more widespread a problem, the better the chances that public officials will be concerned — or forced — to develop remedial measures. Alternatively, problems exhibiting neither large scope nor dramatic growth patterns have little chance in the fierce competition for agenda access. Given the political significance of statistics conveying the scope of a problem, it is understandable that measurement disagreements commonly surround research into public policy issues.

Controversy over the size of the country's homeless population has existed for years. Numbers as high as 3 million and as low as 250,000 have been disseminated by the Community for Creative Non-Violence and Department of Housing and Urban Development, respectively. In general, the higher values are the ones that best support the cause of homeless advocates, barring the danger that extremely high figures could have a boomerang effect by creating feelings of fatalism about the situation.⁵⁴ The practical difficulties of arriving at precise calculation of such a transient, changing, and partially hidden population are extraordinary — among them, deciding the actual level of housing that separates the poorly housed from the homeless, developing inclusive sampling lists, distinguishing between prevalence and incidence, and gathering valid information from survey respondents who may be uncooperative or impaired.⁵⁵ For these reasons, it is impossible to say with certainty how many homeless there are in the United States at this time or how this number has changed over the past decade, even though a number of cities have supplied evidence of rapid growth. To its credit, the Census Bureau dived into these troubled demographic waters when it attempted to enumerate the nation's homeless with a two-day census of its own, in March of 1990.⁵⁶ Yet even supporters of the research undertaking had little hope that it would settle what has now become a highly charged argument.

In political terms, it is clear that persistent uncertainties regarding the size of the homeless population greatly disadvantage the issue within policymaking circles. No one can know for sure where the line falls in documentary efforts between sensationalism and accurate revelation. These circumstances make it easy for officials to offer a modicum of programmatic funding while awaiting the results of definitive research.

Homelessness as an Emergency

When public policymakers define a problem as an "emergency," several consequences follow. First, there is greater visibility. The news media highlight the special emphasis being placed on the issue, and more citizens come to recognize the problem as an important concern. Second, legislators often act more quickly on a problem defined in this manner. Some portion of requested program funds is likely to be allocated in short order. Also, when a problem is defined as an emergency, the implication is that it is of recent origin and potentially solvable. However, the solutions pursued also tend to be of a short-term nature that ignores larger and longer-term ramifications.

Lipsky and Smith argue that two of the major social welfare problems of the 1980s — homelessness and hunger — were both defined as emergencies.⁵⁷ To deal with these ills, localities around the country and the federal government approved modest funding initiatives. Nonprofit emergency service agencies were heavily utilized. And shelter programs and the distribution of food and other surplus commodities served as a

means to meet the most immediate needs of the homeless and hungry populations. By contrast, there is relatively little to point to in the way of a concerted public effort to face the deeper challenges raised by homelessness or hunger to the structure of the American welfare state and its faulty "safety net."

A recent controversy in Florida accents the distinction between emergency interventions against homelessness and more substantial remedies. It also shows how certain kinds of leverage can be used to tilt the balance of public policy toward the latter. This past summer the state denied funding for a Miami plan to move hundreds of homeless people congregating under a downtown highway overpass to a public baseball stadium. The proposed plan entailed the provision of shelter, food, and counseling for a thirty-day period; a contribution of \$300,000 in state money was sought. A spokesman explained Governor Lawton Chiles's position, stating that the governor's "interest is that this be not just a Band-Aid approach but part of a strategic approach to dealing with homeless people. He's prepared to provide funds under those circumstances."⁵⁸ Following the impasse between state and city officials, Miami announced a revised plan to bring social workers and counselors to the homeless to aid them to find employment and permanent housing.⁵⁹

Homelessness and Deservingness

The concept of deservingness is of paramount importance to social welfare provision in the United States. Its policy influence can be traced back at least as far as England's Elizabethan Poor Law of 1601, which divided applicants for relief into the "unworthy" and "worthy" poor, rendering to the former only the most restrictive and meager forms of aid. This framework, which colonists adopted for themselves in the New World, still persists today in such distinctions as that between social insurance and public assistance methods of income maintenance. A suspicion that many recipients are undeserving or unworthy also lies behind continued widespread public antipathy toward the so-called welfare mess. In short, the general rule is that "groups viewed as personally responsible for their own problematic condition and thus considered undeserving tend to be handled through public programs that are limited, stigmatizing, and even punitive in nature."⁶⁰

Some have attempted to use this worthy/unworthy dichotomy to categorize America's homeless population. According to this approach, a substantial segment of the homeless do not merit much public sympathy or resources because they became homeless through their own vices or do not make sufficient effort to escape the condition on their own. Substance abusers, dropouts, and those just too lazy to work are often used as prime examples of this negative behavioral syndrome. President Reagan's infamous phrase of "homeless by choice" also comes to mind in this connection. One careful analysis of various studies, however, estimates that only perhaps 5 percent of all homeless persons would actually fit the profile of the "lazy shiftless bum."⁶¹ Such data notwithstanding, several localities around the nation have reported an emerging social backlash against the homeless, which is evidenced in frequent complaints about panhandlers, incidents of brutal muggings and harassment, and increased political support for cuts in programs to benefit the homeless.⁶²

Just as opponents of large-scale antihomelessness initiatives attempt to relate their stance to the concept of deservingness, so too do the advocates of homelessness programs. Here the emphasis is on the most sympathetic constituents of the

homeless population, such as children, the disabled, veterans, and involuntarily unemployed parents. The point, obviously, is to show that homelessness befalls many who cannot help themselves, who are members of society in good standing, and who have a just claim on the public purse. Thomas Hunsdorfer, director of operations of Saint Francis House, a homeless shelter in Boston, addressed the issue in an editorial: "Here's the bottom line: the homeless in the United States feel like aliens and outcasts — like 'them.' But they are not; they are our neighbors, people from down the street or across town who have problems. They are 'us.' Nothing they have done merits a sentence of life in the shelter system or death on the streets."⁶³

The Affordability of Combating Homelessness

Sooner or later, every public policy discussion turns to the question of whether or not the specified solutions for a problem are affordable. The answer is seldom obvious or incontestable, depending as it does on the costs associated with taking action and on perceived government resources. Affordability debates make use of many kinds of standards, such as dollar comparisons with other existing or proposed programs (contrasting domestic and defense programs is commonplace), references to overall budgetary conditions, and forecasts of the costs of action measured against the probable economic (and social) costs of inaction.⁶⁴

Figures for New York City's shelter budget, which climbed from \$6.8 million in 1978 to more than \$320 million in 1989, suggest the magnitude and direction of expenditures for existing homelessness programs.⁶⁵ An ambitious blueprint for future action against homelessness nationally, drafted by a group of dissenters from the Institute of Medicine's panel on homelessness and health care, calls for housing improvements, raising the minimum wage, expanding welfare cash support, and extending health care benefits to the uninsured. One scholar's estimate of the price tag is about \$30–\$40 billion in new funding annually.⁶⁶ Dramatizing the size of these outlays is the backdrop against which such a recommendation occurs: a public resource base undergoing erosion on all levels due to recession, accumulating budget deficits, and popular antitax sentiments.

Like other aspects of the controversy over defining the homelessness problem, the affordability issue elicits varied responses. Those in charge of public budgets or opposed in principle to growth in the size of government or just unfriendly to the homelessness cause are especially prone to point out inherent fiscal limitations. Advocates for the homeless, on the other hand, maintain that not even these hard times make additional public expenditures inconceivable. With the proper level of commitment, new funding could be found through budget reallocations or new revenue collections. The ultimate "truth" of the matter lies not in any macroeconomic formula, but in the ongoing political dynamic and its operational choices.

There are always many ways to view a public problem, and just as many approaches for attempting corrective action. Long-familiar problems or those that mobilize a small range of political and professional interests obscure this realization due to the narrowness of established public discourse. With the homelessness issue, however, all the complex possibilities lie out in the open. The result is a confusing disharmony of fact and opinion, of causes and effects, that so far has ensnared the policy process and deprived it of focus. Careful empirical research might tease out the rela-

tionships among key variables or identify the most cost-effective intervention strategies available. But this process will take time — and money — and those currently homeless can hardly wait for the findings.

The plural needs of the homeless, their diverse composition, and their marginal social status are ill suited to the response capabilities of the U.S. welfare state, whose largest programs were created to transfer income to narrowly defined categorical populations, such as the elderly and disabled, with long-term attachment to the work force. Conceivably, finding a way to render the homeless adequate assistance could lead to a fundamental reconsideration of the effectiveness and equity of this system. For this to happen, however, the homeless would need to have higher standing politically than they do at present, as well as more consistent media and public interest. Needless to say, it would also help the situation if involved advocacy and provider groups could agree on the nature of the condition being addressed.

The problem-definition perspective is an analytical tool, not a means for making policy prescriptions. But if there is any practical lesson to be learned from its application to homelessness, it is the inadvisability of awaiting consensus before taking further public and private action against this problem. Arising from the failure of so many different support systems, homelessness can be ameliorated from an equal variety of source points, even absent an overarching policy strategy.⁶⁷ So framed, however, it is a task that will severely test the creativity, no less than the resolve, of our faltering American social welfare institution. ♪

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Homelessness Past and Present

The Case of the United States, 1890–1925

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An examination of the professional, political, and popular literature on the nature and extent of homelessness from 1890 to 1925 affords a comparison of the economic and social characteristics of the homeless population at the turn of the century with that of today. The discussion covers the ensuing debates over the causes of homelessness, the various subgroups among the homeless during both periods, and the relative rates of homelessness, the context of extreme poverty and dislocation, and the prevalence of individual disabilities. Except for the growing numbers of homeless families over the past decade, the homeless populations during both eras have many similarities. Then and now, homeless people tend to be young, single, and America-born, with fragmented social supports and a history of dysfunctional family relationships. Although individual difficulties play an important role in determining who is most vulnerable, the authors argue that systemic ills plaguing society virtually ensure the existence of homelessness. Furthermore, during both eras ideologically driven views and moral prejudices have obscured the fundamental question of this country's willingness to care for its neediest members.

With the resurgence of homelessness in the early 1980s came allegations that the problem was new — a peculiar consequence of late industrial society, of Reaganomics, or of the social problems of a class of poor people weaned on welfare. The media popularized the view that although homelessness in the United States has a past, the homeless population today is fundamentally different from that of previous times. Various experts claimed that the characteristics of homeless people, as well as the causes of homelessness, have changed.¹

A careful historical review has proved otherwise. As this article demonstrates, homelessness is in many respects timeless, and the needs of homeless persons continually mirror those of the most economically and socially disadvantaged. While subtle changes in the characteristics of the homeless population have occurred over time, the ceaseless tide of people forced onto the streets points to structural flaws in our society that ensure the existence of this problem. To examine this claim in historical

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context, we have drawn from the professional, political, and popular literature of the period from 1890 to 1925, comparing and contrasting the problem then with the problem now. During both periods, a disproportionate percentage of homeless persons suffered from disabilities that understandably resulted in their increased susceptibility to the vagaries of the economy and the housing market. In addition, persons with depleted support networks were more likely to become homeless.²

Unfortunately, the complexity of factors leading to homelessness has generally been overlooked. During both periods, debates about homelessness have often degenerated into discussions about the character and morality of homeless people. For example, one 1902 depiction describes a hobo as "a moral degenerate" and "a victim of subtle vices which . . . are undermining our national vitality."³ Similarly today, a homeless person suffering from a psychiatric illness or an addiction is not always viewed as someone who has a disorder or is taxed by overwhelming circumstances and in need of immediate help. Instead, the affliction becomes a metaphor for a host of evils, serving as testimony to an individual's unworthiness and becoming a cause for condemnation.

Most important, these incriminating views serve to blame the victim and have led in both periods to calls for reenacting vagrancy laws.⁴ Rather than focusing on systemic changes or creating rational long-term policies, policymakers have marshaled well-worn crisis-oriented and sometimes destructive "solutions." To eliminate homelessness, Americans must acknowledge the causal role played by the economy, housing market, and unraveling communities, as well as by individual vulnerabilities, which determine who will be among the ranks of the homeless. Because we consistently shy away from systemic change and appropriate care for the most vulnerable, America's homeless population endures, relatively unchanged.

We compare the economic and social characteristics of the homeless population today with that of the turn of the century, and discuss similarities between the respective debates. We conclude by examining how ideologically driven views and moral prejudices have, in both eras, served to obscure the fundamental question of whether our society is willing to care for the neediest among us.

Methodology

We have chosen to focus on homelessness during the period from 1890 to 1925 because it encompasses the transition from an agrarian to an industrial society. Although the overall economy expanded during these years, the nation still experienced periods of economic depression, unemployment, and homelessness. Tramps were part of a highly mobile labor pool, which met the needs of a rapidly industrializing nation.⁵ As one observer noted, homeless men were "the pioneers of modern industry. They go hither and thither to the rough, unfinished, uncomfortable places of the world to provide homes and civilized comforts for those of us who follow."⁶ Since members of this group were usually unskilled and seasonally employed, they were often the first to lose their jobs during the many depressions that occurred between 1870 and 1940.

During the 1870s, Americans first identified "tramps" as a serious social problem. Michael Katz argued that tramps became a national obsession.⁷ Discussion of the "tramp problem" was a regular feature in the popular as well as the professional press of the early Progressive period. Administrators, social commentators, and aca-

demics took up the subject of the homeless with great industry and zeal. Even Bram Stoker, author of the 1897 best-seller *Dracula*, made a contribution to this debate, suggesting in 1909 that tramps should be made to bear some sort of indelible "personal marking" to indicate their status.⁸

We draw in large part on written sources published in the United States between 1890 and 1925. As Haskell wrote, the last quarter of the nineteenth century witnessed the professionalization of social work and social science.⁹ Clinicians and researchers in these fields became the experts on homelessness, producing an ample body of demographic and descriptive information on homeless people. They conducted studies of transients and wrote books, pamphlets, and dissertations on the subject.

Although a few social experts conducted systematic quantitative studies of homelessness, their varied methodologies make cross-survey comparisons difficult. Most data were gathered during interviews with residents of poorhouses or workhouses, or with those seeking public assistance. Frank Laubach's 1916 dissertation at Columbia University, "Why There Are Vagrants,"¹⁰ is an example of this type of quantitative research. Laubach gathered information from one hundred men at a wood yard operated by the Charity Organization of New York. He also reported on two data sets collected by Superintendent Whiting in 1914 at the New York Municipal Lodging House: one described the demographic characteristics of 2,000 men while the other described 18,606 men.¹¹ Between 1900 and 1902, Alice Solenberger, a social worker, conducted a now classic study of the thousand homeless men who applied to the Chicago Bureau of Charities.¹² Similarly, between 1902 and 1903, Benjamin Marsh researched the life histories of 118 vagrants at the Wayfarer's Lodge in Philadelphia.¹³ In addition, J. J. McCook asked the mayors of forty cities to complete information about their tramp populations. He asked thirty-two questions about each tramp and received a total of 1,349 autobiographies from fourteen cities.¹⁴ We rely heavily on these studies, especially in our discussion of the origins of homelessness. Of course, the conclusions of these sources must always be scrutinized for methodological deficiencies and biases and evaluated within the context of the Progressive era.

Another set of articles focuses primarily on the origins of the homelessness problem and on potential solutions; these policy-oriented articles generally suggest measures to eradicate homelessness. Often punctuated with cries of moral outrage, they reflect the authors' values and ideological concerns. From 1870 onward, the new social science publications, such as the *Charities' Review* and *Forum*, as well as the popular press, speculated on the causes of the vagrancy problem.¹⁵

We have also used biographical and autobiographical accounts to supplement our study, recognizing that these narratives frequently present a romanticized view of the homeless. Throughout 1907, *Cosmopolitan* published Jack London's series "My Life in the Underworld," a lively account of his adventures as an eighteen-year-old tramp.¹⁶ Nels Anderson's *The Hobo: The Sociology of the Homeless Man* (1923) is another example of this genre; Anderson, a former hobo, became a founding member of the "Chicago School" of sociology.¹⁷ Other narrative descriptions of the homeless population include participant observation studies in which researchers dressed as tramps and lived on the road or in lodging houses.¹⁸

Additionally, in preparing this article, we reviewed various secondary sources, including the work of Katz,¹⁹ Monkkonen,²⁰ Schneider,²¹ and Ringenbach.²²

Definitions

As the historian John Schneider observed, American authors writing during the late nineteenth century constructed numerous typologies of “homeless” men, largely differentiating among hoboes, tramps, and vagrants.²³ Although all were viewed as outsiders, “detached from the soil and the fireside,” there was a hierarchy, a “tramp caste” determined by a person’s relationship to work and to family.²⁴

Hoboes were “merely men out of work,” forced to the road by economic difficulties.²⁵ They were typically young men who wandered in search of work and usually found seasonal or migratory jobs.²⁶ In an admittedly romantic account, Anderson described hoboes as “easy-going individual(s) who live from hand to mouth for the mere joy of living.”²⁷ A tramp also wandered, but he was defined by authorities as a person who was not looking for work. In 1896, the Massachusetts legislature defined a tramp as “any person, not being a minor under seventeen years of age, a blind person, or a person asking charity within his own city or town, who roves about from place to place begging, or living without labor or visible support.”²⁸ Aside from his lack of a home, he lived within the boundaries of the law. At the bottom of the hierarchy was the vagrant, who, in addition to being homeless, was often a social miscreant, engaging in petty thievery and other antisocial conduct.²⁹

The language describing hoboes, tramps, and vagrants was at once value laden and reflective of a colorful and romantic view of the wanderer. Jack London used many terms to capture the complexities of tramp culture: the diminutive “Bo” for hobo, the fraternity of “Haut Beaux”; “musher” from the corruption of the French *marcher*, meaning “to walk”; “gay-cat” for rookie hobo; “comet” for old-timer; and “flopper” for a beggar who resorted to dramatic demonstrations of illness.³⁰ Commonly, a homeless person was given pet names such as “vag, bum, hobo or Weary Willie.”³¹ The use of these names indicated the popularly held conception that a hobo’s life on the road was a matter of choice, even an enjoyable pastime.

Sometimes, the words *hobo*, *tramp*, and *vagrant* were used interchangeably to describe men who traveled from city to city, often hitching a free ride at the expense of the railroad companies. In large towns, they often found cheap lodgings and the companionship of peers. Tramp districts such as New York’s Bowery, Chicago’s Main Stem, and Philadelphia’s Skid Row emerged and began to grow. Similar to today, the numbers of tramps were large and growing, a flourishing shelter network sprang up in response, and commentators concluded that the problem was bigger and more desperate than ever before.

By 1916, the earlier distinctions among hoboes, tramps, and vagrants had blurred. “Vagrant” was consistently interchanged with other words such as “down-and-outs,” “bums,” “beggars,” “tramps,” “driftwoods,” “panhandlers,” and “homeless men.”³² The homogenization of terms has partly persisted into contemporary times, with similar themes predominating: instead of looking for work, most “bums” are seen as looking for handouts. Any residual glamour associated with a freewheeling lifestyle has all but disappeared.

Today we refer to the entire population as “homeless,” a term that implies a broad continuum of economic and residential instability as well as disconnection from community and family ties. Contemporary homelessness, however, reflects more than disrupted ties to work and family. Current distinctions reflect the severity of the low-income housing crisis and the heterogeneity of the population. In contrast to

homeless people in the earlier era who generally had a roof over their heads, "street people" are the most visible subgroup of the homeless population and literally live on the streets, in abandoned buildings, in campgrounds, and in cars. They do not reside in almshouses and lodging houses as they did at the turn of the century³³ or in emergency shelters as many other homeless people do today. Finally, contemporary experts have again created subcategories of homeless persons based on demographic characteristics — adult individuals, families, and youth — which highlight the heterogeneity of the population.³⁴

With these differences in mind, we examine some of the themes common to both eras: the recurrently high rates of homelessness, the context of extreme poverty and economic dislocation, and the enduring characteristics of the homeless population, including the prevalence of individual disabilities.

Extent of the Problem, 1890–1925

Counting the homeless is a formidable if not impossible task, and because of serious methodological problems, the numbers, then and now, are not well suited to comparisons. However, given this caveat, we can make various general statements. The number of homeless persons has always ebbed and flowed with fluctuations in the national economy.³⁵ Although the overall economy expanded during the period from 1890 to 1925, for example, the nation still experienced severe bouts of economic depression and unemployment, which were associated with proportionately larger numbers of homeless persons. During the crash of 1873, 38,000 men lost their homes.³⁶ As the economy recovered during the 1880s, the number of homeless persons declined, but by 1890 the homeless population increased to 45,000, then doubled to approximately 90,000 within three years. During this period nearly 16,000 businesses collapsed, unemployment hovered around 3 million, and the economy functioned at 25 to 30 percent below capacity.³⁷

Conservative estimates of the numbers of tramps who rode the rails between 1890 and 1925 range from 100,000 to 500,000.³⁸ These numbers, while difficult to verify, are based on records kept by big-city shelters, the railroads, and charitable facilities such as poorhouses and jails. During its first eleven years (1901–1912), the New York City Municipal Lodging House sheltered about 542,000 men, 62,000 women, and 18,000 children.³⁹ The Wayfarer's Lodge in Philadelphia housed 28,000 men annually from 1900 to 1907.⁴⁰ During the same period, Chicago institutions sheltered approximately 40,000 to 60,000 homeless each year.⁴¹ The growth of lodging houses throughout the country also reflected the alarming increase in the numbers of vagrants. In 1890, poorhouses were available in only six large cities; twenty years later most cities had a sizable number.⁴²

Today, estimates of the homeless population vary wildly according to the source: numbers range from 250,000 to as many as 3 million nationwide. The federally accepted number of homeless persons is estimated at 500,000–600,000; the figure was derived from a 1987 Urban Institute study of soup kitchens and shelters in large U.S. cities (100,000 or more).⁴³ While single men and women still comprise the majority of the population, increasing numbers of families have joined their ranks. In addition, between 61,500 and 100,000 homeless children sleep in emergency shelters, welfare hotels, abandoned buildings, or cars each night.⁴⁴

Poverty and Unemployment

Homelessness is merely one phase in a cycle of extreme poverty. A decrease in income or increase in expenses places persons living below the poverty level at high risk of becoming homeless. Not surprisingly, surges in the poverty rate are mirrored by increasing numbers of homeless people.

In 1904, Robert Hunter asserted that no fewer than 10 million Americans, 12 percent of the population, were living in poverty. These people were unable "to obtain those necessities which will permit them to maintain a state of physical efficiency"; they were "underclothed, underfed, and miserably housed."⁴⁵ Among the extremely poor were unskilled workers who most often lived at or below the poverty line.

Hunter, using the few available cost-of-living studies, fixed the poverty line at \$460 per year for a family of five in the industrial states of the Northeast and Midwest, and at \$300 per year in the rural South.⁴⁶ On the basis of scattered statistics, Hunter asserted that the 350,000 railroad trackmen and carmen earned less than \$375 per year in the North, and less than \$150 in the South. Cotton mill workers averaged \$360 in the North and \$235 in the South. Sixty percent of the coal miners earned less than \$450. In the mid-Atlantic states, nearly 30 percent of the work force earned less than \$300.⁴⁷

At times, even such low-paying jobs as these were scarce. For example, Frederick Turner, a contemporary expert on the frontier, argued that the depression of the 1890s "did violence to the comfortable assumption that ample employment awaited the worthy and the willing."⁴⁸ And "when the poor face the necessity of becoming paupers," he continued, "when they must apply for charity if they are to live at all, many desert their families and enter the ranks of vagrancy."⁴⁹ As Keyssar noted, "By the end of the Progressive Era, unemployment had become a major item on the nation's list of social problems."⁵⁰

Because of methodological problems, we are unable to compare the job patterns and income levels of homeless persons during the two study periods. Although homeless persons at the turn of the century were more often employed and had greater housing options than their contemporary counterparts, these differences simply represent a matter of degree. For example, following a period of abnormal unemployment during the winter of 1914–1915, the Advisory Social Service Committee of New York's Municipal Lodging House found that 90 percent of the men they studied had been without work for over one week and nearly two-thirds for over a month. Fewer than 15 percent however, had been unemployed for over six months⁵¹ and nearly two-thirds claimed to have been stably employed for an average of 12.2 months during the preceding five years.⁵²

Homeless persons today seem to have more erratic work patterns and are more destitute despite the fact that many are receiving benefits.⁵³ In Rossi's study of today's homeless in Chicago, "only 3% reported having a steady job and only 39% worked for some period during the previous month." Rossi compared this group to homeless persons during the previous two decades and concluded that "the new homeless suffer a much more profound degree of economic destitution."⁵⁴

Furthermore, compared to the earlier period, many more women and children are on the streets today than ever before. Because homelessness is a manifestation of extreme poverty and because families headed by women are disproportionately poor, these families are especially vulnerable to economic vicissitudes. Approx-

mately one third of families headed by women are living below the poverty level. Although the numbers of poor people decreased slightly between 1983 and 1989, the poverty rate climbed in 1990, and 2.1 million Americans became poor. Meanwhile, the poverty rate among children and female-run households remained consistently high throughout the 1980s. Currently, children younger than eighteen make up 38 percent of the nation's 33.6 million poor, a fact mirrored by the growing numbers of children and youth among the contemporary homeless population.⁵⁵

Housing

During 1890–1929, housing production in cities throughout the United States generally lagged behind housing needs. Housing starts between 1890 and 1904, 1919 and 1930, and in 1930 fell far short of the 1899 figure of 342,000 starts, while the number of persons per household remained fairly high (1890, 5.0; 1900, 4.8; 1910, 4.5; 1920, 4.3; 1930, 4.1; the 1970 figure was 3.1 persons per dwelling unit). The housing boom that began in 1905 and lasted until World War I began to meet housing demand, but the war caused a severe setback in housing construction, which was restored by the mid-1920s. However, the Great Depression and World War II again created housing shortages.⁵⁶

Two important trends shed some light on the origins of the housing shortage during this period. The first was the population boom. Between 1890 and 1930, the U.S. population almost doubled as 60 million people were added to the nation's total. Immigration accounted for 37 percent of the increase. Because these "new wave" immigrants settled in port cities where they landed or gravitated to factory and mining towns, housing shortages were particularly acute — and housing conditions particularly crowded and squalid — in these areas.⁵⁷ Still, as the National Housing Association conferences made clear at the turn of the century, housing shortages and rank housing conditions during this period were not confined to urban areas.

A second trend was urban migration. In 1890, 35 percent of the population lived in urban areas. By 1900 the number increased to 39 percent, by 1910 to 46 percent, by 1920 to 52 percent, and by 1930 the number climbed to 56 percent of the population.⁵⁸ Many groups of people were moving to urban environs: native-born Americans moved from farms to cities; native-born blacks moved from the rural South to the urban industrialized North; and immigrants flooded into urban areas.⁵⁹

In *Recent Trends in American Housing* (1931), Edith Wood summarized the housing situation during the period from 1905 to 1929 as follows.

The housing shortage at the end of the War came as a surprise to most people in the United States. . . . In 1917 and 1918 almost no building was done except by the Federal government. Private building was expected to resume briskly as soon as the War was over. It started to do so, but halted. The cost of a home — labor and materials — had doubled.

The volume of home-building in 1919, instead of reducing the shortage, was only 58% of normal. That of 1920 reached only 37% of normal. . . . The maximum shortage was at the end of 1921, when it reached at least one and a quarter million. Then the tide turned. Nineteen twenty-two held its own. Each year thereafter showed substantial gains. By 1926 the end of the shortage was in sight. By 1928 it had been reached. In a nationwide numerical sense, there was no longer a

housing shortage. We were back to where we were before the War, with qualitative rather than quantitative needs. So far as net progress was concerned, ten years had been lost.⁶⁰

Wood reported that during the period of housing shortages, housing standards plummeted and rents soared. Housing structures fell into disrepair, single-family units were turned into apartments, existing apartments were divided into even smaller rental units, unsound vacant housing was occupied, and doubling up of families was common.⁶¹ Jacob Riis eloquently exposed the wretched conditions in New York City's tenements in his classic study, *How The Other Half Lives*.⁶² Overcrowding was rampant in all housing arrangements.

The density of New York's Lower East Side — 1,000 people per acre — exceeded that of any European or even Asian city; its closest rival was one district in Bombay. During the post-Civil War era, cities on the eastern seaboard were congested with tides of foreign immigrants heaped on top of a native population streaming in from the countryside; by 1900 New York's population had tripled and Boston's more than doubled. The housing have-nots packed themselves tightly into cellars and tenements of appalling squalor, deprived of adequate light, air, heat, and running water. Two or three families typically shared a dwelling unit (often a single room) and scores of families shared an outside toilet.⁶³

Thus the housing rebound during the late 1920s was a quantitative one; the country still remained strapped with a severe qualitative housing problem.⁶⁴ However, in contrast to today, persons did not literally reside on the streets.

The severity of the contemporary low-income housing crisis has left many poor persons precariously housed and at high risk of homelessness. Cutbacks in benefits coupled with severe shortages in affordable housing have jeopardized the stability of all people with reduced or fixed incomes. As the median rents of low-income apartments climbed, the number of poor renters markedly increased. The supply of affordable housing was further depleted by gentrification and condominium conversion, a shortage never addressed by the federal government. In the past ten years, the government virtually ceased funding construction or rehabilitation programs for low- and moderate-income housing. Furthermore, in the past decade, new commitments for the construction of public and Section 8, or subsidized, housing fell dramatically from approximately 173,000 to 12,000 apartments.⁶⁵ The crisis in affordability and availability of low-income housing has catapulted many people onto the streets. As Rossi concluded, "Homelessness today is a more severe condition of housing deprivation than in decades past."⁶⁶

The preceding contextual comparisons reveal that the homeless populations during both study periods suffered from poverty, unemployment, and housing shortages. The contemporary homeless population, however, seems to face a bleaker economic situation, with higher levels of unemployment and poverty than its turn-of-the-century counterpart; the recent increase in the number of female-headed families has exacerbated the problem. Whereas in the earlier period there was a cyclical housing shortage and a consistent qualitative housing problem — living conditions were often wretched, and doubling up and substandard living were common — today's acute housing shortage has forced more people to live literally on the streets. With these macro-level contexts in mind, we turn to the characteristics of the homeless population, past and present.

Characteristics of the Homeless Population

Demographics

Despite allegations that the current homeless population tends to be younger than in previous periods, vagrants at the turn of the century were also young and, as today, the percentage of elderly on the streets was small.

Data from sources during the period 1890–1925 suggest that the majority of homeless persons at that time was between twenty and forty years, with an estimated average age of thirty-four years.⁶⁷ In Philadelphia and Chicago, for example, 40 percent were less than thirty years. Among the 19,000 men at the New York City Municipal Lodging House in 1909, 43 percent were under thirty, and in Baltimore 30 percent were between twenty and twenty-five years.⁶⁸ The percentage of persons over fifty years old was correspondingly small — in most studies not exceeding 15 percent.⁶⁹

Similar to today, the systematic studies of the homeless published nearly a century ago revealed that an estimated 74 to 80 percent of vagrants were single; only 8 to 12 percent were married.⁷⁰ Fourteen percent had lost their spouses, and 26 percent had deserted their wives and families.⁷¹ Approximately 58 percent had no contact with their families, and only 33 percent had homes to which they could return if they wished.⁷²

The data concerning homeless women are scarce, but a number of studies suggest that female vagrancy was a significant problem. During the eighteenth century, the number of female vagrants was extremely large, often equaling one half of the homeless population. One hundred years later, the Municipal Lodging House in New York City housed one woman for every 8.7 men, a ratio indicating that the problem was still considerable.⁷³ Although male vagrants outnumbered females during this time, female vagrancy was less tolerated by public opinion, as well as by the authorities. In terms of contemporary figures, Rossi's Chicago study (1985–1986) reported that approximately 25 percent of the homeless population in Chicago was female;⁷⁴ this percentage has been corroborated by other contemporary researchers.⁷⁵

A notable difference between the populations of the two periods, however, is the virtual lack of homeless families during the earlier era. Though homeless families were rarely mentioned in the literature of the early 1900s, it is clear that those families who were homeless faced particularly severe struggles. Solenberger thought that

a most interesting chapter might be written about the tramp-women and the tramp-families on the road, figures as familiar to charity workers as men tramps, and whose restoration to normal living presents even more serious and difficult problems.⁷⁶

Homeless families were viewed as more difficult to rehabilitate and more costly to the state. Edward Devine declared that homeless families should be more “dreaded than the single vagrant, for charity will respond to appeals on behalf of a dependent family even to the extent of providing a living for months together if the head of the family is not employed.”⁷⁷ Today, homeless families are the fastest growing segment of the homeless population and comprise approximately one-third overall. Consisting predominantly of families headed by women, they tend to have two to three children, most of whom are preschoolers aged three to five years old.⁷⁸

Although vagrancy was commonly believed to be endemic among immigrants, three of the quantitative studies of the homeless — Marsh, Laubach, and Solen-

berger — revealed that more than two thirds of all vagrants were American-born, with the remainder of European origin.⁷⁹ (In New York City a higher percentage of the homeless were foreigners, probably due to the city's role as a major port of entry.)⁸⁰ In contrast, homeless families today generally have grown up in or near the community where they are being sheltered. Although some are geographically mobile and foreign-born, the majority are indigenous.

In statements prefiguring similar commentary today, numerous writers during the late 1800s asserted that homelessness was due to unstable family life. According to Laubach, "the ultimate causes of vagrancy . . . (were) often to be found in the lack of good mothers" and solid, supportive families.⁸¹ Laubach and Marsh both reported that a large number of vagrants had grown up in unstable family situations, making them more likely to have fragmented family ties as adults.⁸²

Many were orphaned or came from abusive families and later turned their backs on family life. While 48 to 59 percent had lost one or both parents at a young age, 25 percent had run away to escape abuse and violence. Forty-five percent reported that their fathers drank excessively, and 17 percent said that their mothers had abused alcohol.⁸³ Of course, pinpointing what constituted "alcohol abuse" and "alcoholism" in those years — during which there was an energetic and influential temperance movement — is extremely difficult.

The childhood experiences of today's homeless men resonate with those of their forefathers. In their 1985 study of hundreds of "first-timer" and veteran shelter residents, Susser et al.⁸⁴ found "a high frequency of a history of institutional separation from the family during childhood. Similarly, a childhood history of delinquency or running away was common." Fifteen percent of the first-timers and 12 percent of the veterans reported histories of psychiatric hospitalization. Before age seventeen, 13 percent of the first-timers and 17 percent of the veterans had been placed in foster care, group homes, or special residences. Susser et al. also found that "running away for an extended period, school expulsion, going to jail or reform school, or more than one of these childhood events was reported by 43% of the first-timers and 34% of the [veteran] sample."⁸⁵

Individual Disadvantage and Disabilities

Essayists and researchers at the turn of the century divided the individual characteristics that could interfere with a person's ability to work into four categories: "moral, temperamental, mental and physical."⁸⁶ Moral and temperamental categories overlapped and reflected harsh value judgments about the antisocial nature of particular habits and behaviors. Temperamental factors included pernicious character traits, such as wanderlust, laziness, disdain of work, hasty tempers, and hypocrisy, while moral factors included "vices" such as drunkenness, drug abuse, sensuality, gambling, and crimes.⁸⁷ Mental and physical disqualifications referred to various illnesses and chronically disabling conditions.

Experts during both eras agreed that a disproportionate percentage of homeless persons suffer from such disabilities as mental illness and addictions, and that these difficulties often interfere with their capacity to work and to remain self-sufficient. However, similar to today's commentators, many writers recognized that the causal link between individual vulnerabilities and vagrancy was tenuous, since individual factors might actually result from homelessness and were always secondary to macro-level factors like the economic recession. During both eras, the relative con-

tributions of these factors to the risk of homelessness was hotly debated. The following discussion focuses primarily on the turn of the century; the current debate echoes many of the issues raised.

Temperamental Factors

Temperamental traits were defined as “eccentricities [that] . . . disqualified men for cooperative effort and rendered them unprofitable as employees.”⁸⁸ Wanderlust was the most commonly cited peculiarity that made it difficult for the vagrant to work. Thirty-one percent of the men at the Wayfarer’s Lodge in Philadelphia were said to suffer from it.⁸⁹ While popular writers like Jack London romanticized the life of the wanderer, others suggested that wanderlust was commonly linked to domestic difficulties. Laubach, for example, reported that many vagrants, allegedly seized by wanderlust (a predominantly male malady), had abandoned conflicted marital and family situations.⁹⁰

Because the number of vagrants appeared to have increased after the Civil War, a number of commentators posited that many veterans had been unable to settle back into civilian life after roaming with the army. Some authors thought that these vagrants had merely developed an appetite for the rough, wandering life of the brigade. However, it remains unclear how often war-related physical or psychological disabilities, similar to those experienced by Vietnam veterans today, alienated these men from the social mainstream.

Similar to writers at the turn of the century, some contemporary analysts have also romanticized life on the streets. Although not invoking temperamental factors, commentators such as President Ronald Reagan have stated that homeless people are homeless by choice. Rather than emphasizing that structural factors in our society ensure homelessness, and that life on the streets is fraught with extreme dangers and stresses as well as constant assaults on one’s dignity and self-respect, they have erroneously concluded that personal choice is often the critical issue in its origins.

Moral Factors

Many commentators viewed drunkenness as, in the words of Laubach, “the greatest immediate factor in the making of vagrants.”⁹¹ Because alcoholism was regarded as within the conscious control of the abuser, it was considered a moral problem. Depending on the sample and the criteria used, estimates of the percentage of vagrants addicted to alcohol ranged from approximately 20 percent to 80 percent.⁹² But statistics about alcoholics must be evaluated carefully, since definitions of “alcoholism” varied greatly.

Physicians who examined 2,000 men at the New York Municipal Lodging House in 1914 diagnosed approximately 39 percent as having alcoholism. Their director, Dr. James Alexander Miller, suspected that these “figures probably do not represent by any means the number of individuals who were alcoholic but are rather indicative only of the number who manifested acute evidence of that condition at the time of the investigation.”⁹³ Superintendent Whiting of the Municipal Lodging House estimated that “30% had entered the life of vagrancy through the saloon.”⁹⁴ Sixty-six percent of the men who came to the Chicago Free Municipal Lodging House lived on the streets because of their alcohol abuse.⁹⁵ While Laubach described 80 percent of the men in his study as “slaves to rum to such an extent that they crave it as food,” Solenberger, citing the smallest percentage, found only 195 alcoholics among the 1,000 homeless men she studied.⁹⁶ Solenberger, however, differentiated between the

behaviors associated with drinking and the medical effects. She concluded that only sixteen of these men had alcohol problems serious enough to interfere with work.

Most authors recognized that the causal relationship between alcoholism and homelessness was unclear. The more time vagrants spent on the streets, the more they turned to alcohol. "Frequently the illnesses are attributable to drink or immorality," wrote Laubach, "but more often perhaps, they are attributable to exposure, irregularity of eating and wretched food."⁹⁷

The decriminalization of the public inebriate in 1965 has helped to transform alcoholism from a moral to a medical problem. Although images of the skid row alcoholic are still colored by moral invectives not dissimilar to those expressed at the turn of the century, a large contemporary literature has documented the nature and extent of the substance-abuse problem among homeless persons, and its relationship to the antecedents, causes, and consequences of homelessness.⁹⁸ Some of the issues debated in the earlier era are still evident today.

Mental Factors

Social workers at the turn of the century made little distinction between neurologic and psychiatric disorders, or between mental illness and retardation. Thus, this category includes neurologic illnesses (syphilis), epilepsy, retardation ("feeble-mindedness") and chronic mental illness (insanity). Laubach, Solenberger, and Whiting found that approximately 10 to 25 percent suffered from some sort of mental illness.⁹⁹ Solenberger noted that her figure of 10 percent would be greatly increased "if there were added the border-line cases" of mental imbalance such as wanderlust, crime, and vice. According to Solenberger, 64 percent of those with mental disorders were actually insane, and about one third of those were also alcoholics.¹⁰⁰ Solenberger reported that at least half the men she studied had been "inmates of institutions," primarily insane asylums, poorhouses, homes for the incurable, and jails.¹⁰¹

Solenberger attributed the presence of mentally ill individuals among the homeless to lack of social connections and to institutional inadequacy. Twenty-five percent of the homeless men she studied had neither relatives nor friends. In addition, the system of public institutions failed to contain chronically dysfunctional individuals within a supportive or custodial network. For example, after the age of sixteen, a feeble-minded person was no longer eligible for hospital admission.¹⁰²

Solenberger researched the question of whether men become "homeless and vagrant because of their insanity, or insane because of their vagrancy."¹⁰³ After documenting the presence of mental disorders well before the individual became a transient, Solenberger concluded that "insanity acts as a cause of vagrancy more often than vagrancy as a cause of insanity."¹⁰⁴ Once on the streets, Solenberger found, the insane homeless were more likely to suffer from serious starvation and exposure than other vagrants. Often their delusions prevented them from accepting care and shelter.¹⁰⁵

Today, a spate of studies has documented the extent and nature of mental illness among homeless adult individuals. Researchers generally agree that approximately one third of this subgroup suffers from schizophrenia and other psychotic disorders. The failure of deinstitutionalization, the relative lack of comprehensive community alternatives, and the razing of the SROs in many large cities during the 1980s renders these disabled individuals particularly vulnerable to becoming homeless.¹⁰⁶

Although many experts have focused on the recent abandonment of the chronically mentally ill to the streets, adequate resources have never been allocated, whether in the hospital or in the community care of the chronically mentally ill. Because of the relative lack of institutional and family supports, mentally ill people have frequently been forced to turn to emergency shelters for refuge.¹⁰⁷

Physical Factors

Many vagrants at the turn of the century suffered from some form of physical disability. Laubach found that as many as 77 percent of the men he studied were physically impaired, but predicted that if they received appropriate medical treatment 43 percent would improve significantly.¹⁰⁸ Solenberger reported that 627 men (63%) in her study were in poor health and listed the following distribution of disorders: crippling handicap (27%), tuberculosis (15%), mental disorders (14%), blindness (7%), rheumatism (6%), paralysis (6%), aging (5.6%), and convalescence (5.3%).¹⁰⁹ Figures from New York's Municipal Lodging House generally confirm Solenberger's findings.

Many men who were maimed in industrial and railroad accidents joined the vagrant population. Without antibiotics, and sometimes without medical treatment at all, a minor injury might become crippling or even fatal. Ernest Poole, writing in *Everybody's Magazine*, claimed that

in the past 10 years, the railroads, the mines, the factories, mills and docks have maimed over a million men. And the public is paying the pensions. For thousands of cripples, thrown out of their regular work, take to the road; and with no miracle coming to turn them back, become out-and-out tramps and bums, doing no work at all, begging and stealing their way.¹¹⁰

A small percentage of homeless tramps suffered from physical disorders resulting from old age. Generally, the aged homeless consisted of men who had been industrious most of their lives, but who were too infirm to pursue their work. According to Solenberger, they had to choose between the "Old Folks' Home and the freedom of vagrancy."¹¹¹

A 1988 report by the Institute of Medicine on the health needs of homeless persons today indicates that the rates of both acute and chronic medical illnesses are higher among the homeless than among comparable groups in the general population.¹¹² The authors conclude that chronic medical disabilities may be associated with a higher risk of becoming homeless, and that once people are homeless, life on the streets causes them a range of medical problems, exacerbates others, and invariably makes treatment difficult. Infections and diseases worsened by overcrowding are common; for example, tuberculosis has become epidemic in some shelters and their neighboring communities. During both eras, the nature of the problems and illnesses common among homeless people also partly reflects problems in the service delivery system. For example, the elderly today have become far less vulnerable to homelessness because of increased benefit and assistance programs, such as Social Security and congregate housing.

Homeless persons mirror the extremely poor; as the profile of poor persons changes, so does that of the homeless population. For the most part, the populations during both periods had more likenesses than differences: they tended to be young,

single, and American-born, had fragmented social supports, and often grew up in dysfunctional families. Chronically disabled individuals, particularly those without adequate institutional protection, comprised a large percentage of the homeless during both periods. Although today's experts have documented a dramatic increase in the numbers of women among the homeless — 3 percent in the fifties and sixties to 25 percent today — the number of women in previous eras was also high. At the turn of the century approximately 10 percent of the tramp population was female. A notable difference between the populations is the virtual lack of homeless families in the earlier era. Today, families are the fastest growing segment of the homeless population, comprising nearly one third of the overall number.

During the early nineteenth century, vagrancy was sometimes attributed to individual habits and character traits rather than to economic dislocation and extreme poverty. Although physical disability was regarded as a “legitimate” reason not to work, the gray area between men who were able to work and those who could not provoked heated moral commentary. Solenberger, for example, believed that a man's ability to work depended on his character, temperament, and moral fiber rather than on the nature of the disability.¹¹³ She compared men who overcame catastrophic physical disabilities to others who sank into lives of “moral degeneracy and vagrancy,” burdened by only minor physical problems. Similar to experts in both eras, she did not understand that systemic ills plaguing our society virtually ensure homelessness and that individual difficulties play an important role in determining who is most vulnerable in this context.

The homeless of both periods were primarily victims of economic dislocation; their numbers fluctuated with the health of the economy. At the turn of the century, the rapidly growing tramp problem was primarily related to unemployment and underemployment. Today, homeless persons are also subject to the vagaries of the economy, but as Rossi has described, housing deprivation is more acute today than it has been in decades past.¹¹⁴

Polarizing the debate about the origins of homelessness and not acknowledging the primacy of economic factors impugned its victims and cleared a path for the introduction of punitive measures against persons who were different from the so-called mainstream either on the basis of extreme poverty or disability. Some of the prejudices are still apparent in our contemporary management of homelessness, especially with respect to the homeless who are mentally disabled, alcoholic, or physically ill (for example, HIV victims).

The punitive “solutions” of the past, such as workhouses and labor colonies, and of the present, such as the revived effort to enforce vagrancy laws, partly stem from this oppositional understanding of the antecedents of homelessness. The emergence of bias in turn-of-the-century analyses also grew out of tendencies to treat homelessness as a monolithic entity, overlooking the coupling of systemic and individualistic determinants. Equally dangerous, various writers at the turn of the century — like some contemporary analysts — have romanticized life on the streets, erroneously concluding that personal choice is the critical issue in the origins of homelessness.

Whether on the basis of extreme poverty, chronic disability, or both, persons without homes have always been misunderstood or stigmatized by the population at large. Indeed, there were romantic heroes who traveled the rails looking for adventure and supporting themselves with seasonal labor, and there are people today who

have been evicted or are escaping dysfunctional families or abusive husbands. But there have always been persons seriously disabled by alcoholism, mental disorders, and physical handicaps, problems that contributed significantly to their susceptibility to economic displacement. The turn-of-the-century debate highlights the speciousness of aspects of our contemporary debate and should encourage us to tackle the real question of how to address the profound dislocation plaguing the most vulnerable among us. 🐼

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On Dumpster Diving

Lars Eighner

Long before I began Dumpster diving I was impressed with Dumpsters, enough so that I wrote the Merriam-Webster research service to discover what I could about the word “Dumpster.” I learned from them that “Dumpster” is a proprietary word belonging to the Dempsey Dumpster company.

Since then I have dutifully capitalized the word although it was lowercased in almost all of the citations Merriam-Webster photocopied for me. Dempsey’s word is too apt. I have never heard these things called anything but Dumpsters. I do not know anyone who knows the generic name for these objects. From time to time, however, I hear a wino or hobo give some corrupted credit to the original and call them Dipsy Dumpsters.

I began Dumpster diving about a year before I became homeless.

I prefer the term “scavenging” and use the word “scrounging” when I mean to be obscure. I have heard people, evidently meaning to be polite, use the word “foraging,” but I prefer to reserve that word for gathering nuts and berries and such which I do also according to the season and the opportunity. “Dumpster diving” seems to me to be a little too cute and, in my case, inaccurate because I lack the athletic ability to lower myself into the Dumpsters as the true divers do, much to their increased profit.

I like the frankness of the word “scavenging,” which I can hardly think of without picturing a big black snail on an aquarium wall. I live from the refuse of others. I am a scavenger. I think it a sound and honorable niche, although if I could I would naturally prefer to live the comfortable consumer life, perhaps — and only perhaps — as a slightly less wasteful consumer owing to what I have learned as a scavenger.

While my dog Lizbeth and I were still living in the house on Avenue B in Austin, as my savings ran out, I put almost all my sporadic income into rent. The necessities of daily life I began to extract from Dumpsters. Yes, we ate from Dumpsters. Except for jeans, all my clothes came from Dumpsters. Boom boxes, candles, bedding, toilet paper, medicine, books, a typewriter, a virgin male love doll, change sometimes amounting to many dollars: I acquired many things from the Dumpsters.

Lars Eighner became homeless in 1988 after leaving a job he had held for ten years as an attendant at a state hospital in Austin, Texas. He lives in a small apartment in Austin and continues to scavenge. This article was originally published in the Fall 1990 issue of The Threepenny Review. Reprinted with permission.

I have learned much as a scavenger. I mean to put some of what I have learned down here, beginning with the practical art of Dumpster diving and proceeding to the abstract.

What is safe to eat?

After all, the finding of objects is becoming something of an urban art. Even respectable employed people will sometimes find something tempting sticking out of a Dumpster or standing beside one. Quite a number of people, not all of them of the bohemian type, are willing to brag that they found this or that piece in the trash. But eating from Dumpsters is the thing that separates the dilettanti from the professionals.

Eating safely from the Dumpsters involves three principles: using the senses and common sense to evaluate the condition of the found materials, knowing the Dumpsters of a given area and checking them regularly, and seeking always to answer the question "Why was this discarded?"

Perhaps everyone who has a kitchen and a regular supply of groceries has, at one time or another, made a sandwich and eaten half of it before discovering mold on the bread or got a mouthful of milk before realizing the milk had turned. Nothing of the sort is likely to happen to a Dumpster diver because he is constantly reminded that most food is discarded for a reason. Yet a lot of perfectly good food can be found in Dumpsters.

Canned goods, for example, turn up fairly often in the Dumpsters I frequent. All except the most phobic people would be willing to eat from a can even if it came from a Dumpster. Canned goods are among the safest of foods to be found in Dumpsters, but are not utterly foolproof.

Although very rare with modern canning methods, botulism is a possibility. Most other forms of food poisoning seldom do lasting harm to a healthy person. But botulism is almost certainly fatal and often the first symptom is death. Except for carbonated beverages, all canned goods should contain a slight vacuum and suck air when first punctured. Bulging, rusty, dented cans and cans that spew when punctured should be avoided, especially when the contents are not very acidic or syrupy.

Heat can break down the botulin, but this requires much more cooking than most people do to canned goods. To the extent that botulism occurs at all, of course, it can occur in cans on pantry shelves as well as in cans from Dumpsters. Need I say that home-canned goods found in Dumpsters are simply too risky to be recommended.

From time to time one of my companions, aware of the source of my provisions, will ask, "Do you think these crackers are really safe to eat?" For some reason it is most often the crackers they ask about.

This question always makes me angry. Of course I would not offer my companion anything I had doubts about. But more than that I wonder why he cannot evaluate the condition of the crackers for himself. I have no special knowledge and I have been wrong before. Since he knows where the food comes from, it seems to me he ought to assume some of the responsibility for deciding what he will put in his mouth.

For myself I have few qualms about dry foods such as crackers, cookies, cereal, chips, and pasta if they are free of visible contaminants and still dry and crisp. Most often such things are found in the original packaging, which is not so much a positive sign as it is the absence of a negative one.

Raw fruits and vegetables with intact skins seem perfectly safe to me, excluding of course the obviously rotten. Many are discarded for minor imperfections which can

be pared away. Leafy vegetables, grapes, cauliflower, broccoli, and similar things may be contaminated by liquids and may be impractical to wash.

Candy, especially hard candy, is usually safe if it has not drawn ants. Chocolate is often discarded only because it has become discolored as the cocoa butter de-emulsified. Candying after all is one method of food preservation because pathogens do not like very sugary substances.

All of these foods might be found in any Dumpster and can be evaluated with some confidence largely on the basis of appearance. Beyond these are foods which cannot be correctly evaluated without additional information.

I began scavenging by pulling pizzas out of the Dumpster behind a pizza delivery shop. In general prepared food requires caution, but in this case I knew when the shop closed and went to the Dumpster as soon as the last of the help left.

Such shops often get prank orders, called "bogus." Because help seldom stays long at these places pizzas are often made with the wrong topping, refused on delivery for being cold, or baked incorrectly. The products to be discarded are boxed up because inventory is kept by counting boxes: a boxed pizza can be written off; an unboxed pizza does not exist.

I never placed a bogus order to increase the supply of pizzas and I believe no one else was scavenging in this Dumpster. But the people in the shop became suspicious and began to retain their garbage in the shop overnight.

While it lasted I had a steady supply of fresh, sometimes warm pizza. Because I knew the Dumpster I knew the source of the pizza, and because I visited the Dumpster regularly I knew what was fresh and what was yesterday's.

The area I frequent is inhabited by many affluent college students. I am not here by chance; the Dumpsters in this area are very rich. Students throw out many good things, including food. In particular they tend to throw everything out when they move at the end of a semester, before and after breaks, and around midterm when many of them despair of college. So I find it advantageous to keep an eye on the academic calendar.

The students throw food away around the breaks because they do not know whether it has spoiled or will spoil before they return. A typical discard is a half jar of peanut butter. In fact nonorganic peanut butter does not require refrigeration and is unlikely to spoil in any reasonable time. The student does not know that, and since it is Daddy's money, the student decides not to take a chance.

Opened containers require caution and some attention to the question "Why was this discarded?" But in the case of discards from student apartments, the answer may be that the item was discarded through carelessness, ignorance, or wastefulness. This can sometimes be deduced when the item is found with many others, including some that are obviously perfectly good.

Some students, and others, approach defrosting a freezer by chucking out the whole lot. Not only do the circumstances of such a find tell the story, but also the mass of frozen goods stays cold for a long time and items may be found still frozen or freshly thawed.

Yogurt, cheese, and sour cream are items that are often thrown out while they are still good. Occasionally I find a cheese with a spot of mold, which of course I just pare off, and because it is obvious why such a cheese was discarded, I treat it with less suspicion than an apparently perfect cheese found in similar circumstances. Yogurt is often discarded, still sealed, only because the expiration date on the carton had passed. This is one of my favorite finds because yogurt will keep for several days, even in warm weather.

Students throw out canned goods and staples at the end of semesters and when they give up college at midterm. Drugs, pornography, spirits, and the like are often discarded when parents are expected — Dad's day, for example. And spirits also turn up after big party weekends, presumably discarded by the newly reformed. Wine and spirits, of course, keep perfectly well even once opened.

My test for carbonated soft drinks is whether they still fizz vigorously. Many juices or other beverages are too acid or too syrupy to cause much concern provided they are not visibly contaminated. Liquids, however, require some care.

One hot day I found a large jug of Pat O'Brian's Hurricane mix. The jug had been opened, but it was still ice cold. I drank three large glasses before it became apparent to me that someone had added the rum to the mix, and not a little rum. I never tasted the rum and by the time I began to feel the effects I had already ingested a very large quantity of the beverage. Some divers would have considered this is a boon, but being suddenly and thoroughly intoxicated in a public place in the early afternoon is not my idea of a good time.

I have heard of people maliciously contaminating discarded food and even hand-outs, but mostly I have heard of this from people with vivid imaginations who have had no experience with the Dumpsters themselves. Just before the pizza shop stopped discarding its garbage at night, jalapeños began showing up on most of the discarded pizzas. If indeed this was meant to discourage me it was a wasted effort because I am native Texan.

For myself, I avoid game, poultry, pork, and egg-based foods whether I find them raw or cooked. I seldom have the means to cook what I find, but when I do I avail myself of plentiful supplies of beef which is often in very good condition. I suppose fish becomes disagreeable before it becomes dangerous. The dog is happy to have any such thing that is past its prime and, in fact, does not recognize fish as food until it is quite strong.

Home leftovers, as opposed to surpluses from restaurants, are very often bad. Evidently, especially among students, there is a common type of personality that carefully wraps up even the smallest leftover and shoves it into the back of the refrigerator for six months or so before discarding it. Characteristic of this type are the reused jars and margarine tubs which house the remains.

I avoid ethnic foods I am unfamiliar with. If I do not know what it is supposed to look like when it is good, I cannot be certain I will be able to tell if it is bad.

No matter how careful I am I still get dysentery at least once a month, oftener in warm weather. I do not want to paint too romantic a picture. Dumpster diving has serious drawbacks as a way of life.

I learned to scavenge gradually, on my own. Since then I have initiated several companions into the trade. I have learned that there is a predictable series of stages a person goes through in learning to scavenge.

At first the new scavenger is filled with disgust and self-loathing. He is ashamed of being seen and may lurk around, trying to duck behind things, or he may try to dive at night.

(In fact, most people instinctively look away from a scavenger. By skulking around, the novice calls attention to himself and arouses suspicion. Diving at night is ineffective and needlessly messy.)

Every grain of rice seems to be a maggot. Everything seems to stink. He can wipe the egg yolk off the found can, but he cannot erase the stigma of eating garbage out of his mind.

That stage passes with experience. The scavenger finds a pair of running shoes that fit and look and smell brand new. He finds a pocket calculator in perfect working order. He finds pristine ice cream, still frozen, more than he can eat or keep. He begins to understand: people do throw away perfectly good stuff, a lot of perfectly good stuff.

At this stage, Dumpster shyness begins to dissipate. The diver, after all, has the last laugh. He is finding all manner of good things which are his for the taking. Those who disparage his profession are the fools, not he.

He may begin to hang onto some perfectly good things for which he has neither a use nor a market. Then he begins to take note of the things which are not perfectly good but are nearly so. He mates a Walkman with broken earphones and one that is missing a battery cover. He picks up things which he can repair.

At this stage he may become lost and never recover. Dumpsters are full of things of some potential value to someone and also of things which never have much intrinsic value but are interesting. All the Dumpster divers I have known come to the point of trying to acquire everything they touch. Why not take it, they reason, since it is all free.

This is, of course, hopeless. Most divers come to realize that they must restrict themselves to items of relatively immediate utility. But in some cases the diver simply cannot control himself. I have met several of these pack-rat types. Their ideas of the values of various pieces of junk verge on the psychotic. Every bit of glass may be a diamond, they think, and all that glisters, gold.

I tend to gain weight when I am scavenging. Partly this is because I always find far more pizza and doughnuts than water-packed tuna, nonfat yogurt, and fresh vegetables. Also I have not developed much faith in the reliability of Dumpsters as a food source, although it has been proven to me many times. I tend to eat as if I have no idea where my next meal is coming from. But mostly I just hate to see food go to waste and so I eat much more than I should. Something like this drives the obsession to collect junk.

As for collecting objects, I usually restrict myself to collecting one kind of small object at a time, such as pocket calculators, sunglasses, or campaign buttons. To live on the street I must anticipate my needs to a certain extent: I must pick up and save warm bedding I find in August because it will not be found in Dumpsters in November. But even if I had a home with extensive storage space I could not save everything that might be valuable in some contingency.

I have proprietary feelings about my Dumpsters. As I have suggested, it is no accident that I scavenge from Dumpsters where good finds are common. But my limited experience with Dumpsters in other areas suggests to me that it is the population of competitors rather than the affluence of the dumpers that most affects the feasibility of survival by scavenging. The large number of competitors is what puts me off the idea of trying to scavenge in places like Los Angeles.

Curiously, I do not mind my direct competition, other scavengers, so much as I hate the can scroungers.

People scrounge cans because they have to have a little cash. I have tried scrounging cans with an able-bodied companion. Afoot a can scrounger simply cannot make

more than a few dollars a day. One can extract the necessities of life from the Dumpsters directly with far less effort than would be required to accumulate the equivalent value in cans.

Can scroungers, then, are people who *must* have small amounts of cash. These are drug addicts and winos, mostly the latter because the amounts of cash are so small.

Spirits and drugs do, like all other commodities, turn up in Dumpsters and the scavenger will from time to time have a half bottle of a rather good wine with his dinner. But the wino cannot survive on these occasional finds; he must have his daily dose to stave off the DTs. All the cans he can carry will buy about three bottles of Wild Irish Rose.

I do not begrudge them the cans, but can scroungers tend to tear up the Dumpsters, mixing the contents and littering the area. They become so specialized that they can see only cans. They earn my contempt by passing up change, canned goods, and readily hockable items.

There are precious few courtesies among scavengers. But it is a common practice to set aside surplus items: pairs of shoes, clothing, canned goods, and such. A true scavenger hates to see good stuff go to waste and what he cannot use he leaves in good condition in plain sight.

Can scoungers lay waste to everything in their path and will stir one of a pair of good shoes to the bottom of a Dumpster, to be lost or ruined in the muck. Can scoungers will even go through individual garbage cans, something I have never seen a scavenger do.

Individual garbage cans are set out on the public easement only on garbage days. On other days going through them requires trespassing close to a dwelling. Going through individual garbage cans without scattering litter is almost impossible. Litter is likely to reduce the public's tolerance of scavenging. Individual garbage cans are simply not as productive as Dumpsters; people in houses and duplexes do not move as often and for some reason do not tend to discard as much useful material. Moreover, the time required to go through one garbage can that serves one household is not much less than the time required to go through a Dumpster that contains the refuse of twenty apartments.

But my strongest reservation about going through individual garbage cans is that this seems to me a very personal kind of invasion to which I would object if I were a householder. Although many things in Dumpsters are obviously meant never to come to light, a Dumpster is somehow less personal.

I avoid trying to draw conclusions about the people who dump in the Dumpsters I frequent. I think it would be unethical to do so, although I know many people will find the idea of scavenger ethics too funny for words.

Dumpsters contain bank statements, bills, correspondence, and other documents, just as anyone might expect. But there are also less obvious sources of information. Pill bottles, for example. The labels of pill bottles contain the name of the patient, the name of the doctor, and the name of the drug. AIDS drugs and antipsychotic medicines, to name but two groups, are specific and are seldom prescribed for any other disorders. The plastic compacts for birth control pills usually have complete label information.

Despite all of this sensitive information, I have had only one apartment resident object to my going through the Dumpster. In that case it turned out the resident was

a university athlete who was taking bets and who was afraid I would turn up his wager slips.

Occasionally a find tells a story. I once found a small paper bag containing some unused condoms, several partial tubes of flavored sexual lubricant, a partially used compact of birth control pills, and the torn pieces of a picture of a young man. Clearly she was through with him and planning to give up sex altogether.

Dumpster things are often sad — abandoned teddy bears, shredded wedding books, despaired-of sales kits. I find many pets lying in state in Dumpsters. Although I hope to get off the streets so that Lizbeth can have a long and comfortable old age, I know this hope is not very realistic. So I suppose when her time comes she too will go into a Dumpster. I will have no better place for her. And after all, for most of her life her livelihood has come from the Dumpster. When she finds something I think is safe that has been spilled from the Dumpster I let her have it. She already knows the route around the best Dumpsters. I like to think that if she survives me she will have a chance of evading the dogcatcher and of finding her sustenance on the route.

Silly vanities also come to rest in the Dumpsters. I am a rather accomplished needleworker. I get a lot of materials from the Dumpsters. Evidently sorority girls, hoping to impress someone, perhaps themselves, with their mastery of a womanly art, buy a lot of embroider-by-number kits, work a few stitches horribly, and eventually discard the whole mess. I pull out their stitches, turn the canvas over, and work an original design. Do not think I refrain from chuckling as I make original gifts from these kits.

I find diaries and journals. I have often thought of compiling a book of literary found objects. And perhaps I will one day. But what I find is hopelessly commonplace and bad without being, even unconsciously, camp. College students also discard their papers. I am horrified to discover the kind of paper which now merits an A in an undergraduate course. I am grateful, however, for the number of good books and magazines the students throw out.

In the area I know best I have never discovered vermin in the Dumpsters, but there are two kinds of kitty surprise. One is alley cats which I meet as they leap, claws first, out of Dumpsters. This is especially thrilling when I have Lizbeth in tow. The other kind of kitty surprise is a plastic garbage bag filled with some ponderous, amorphous mass. This always proves to be used cat litter.

City bees harvest doughnut glaze and this makes the Dumpster at the doughnut shop more interesting. My faith in the instinctive wisdom of animals is always shaken whenever I see Lizbeth attempt to catch a bee in her mouth, which she does whenever bees are present. Evidently some birds find Dumpsters profitable, for birdie surprise is almost as common as kitty surprise of the first kind. In hunting season all kinds of small game turn up in Dumpsters, some of it, sadly, not entirely dead. Curiously, summer and winter, maggots are uncommon.

The worst of the living and near-living hazards of the Dumpsters are the fire ants. The food that they claim is not much of a loss, but they are vicious and aggressive. It is very easy to brush against some surface of the Dumpster and pick up half a dozen or more fire ants, usually in some sensitive area such as the underarm. One advantage of bringing Lizbeth along as I make Dumpster rounds is that, for obvious reasons, she is very alert to ground-based fire ants. When Lizbeth recognizes the signs of fire ant infestation around our feet she does the Dance of the Zillion Fire Ants. I have learned not to ignore this warning from Lizbeth, whether I perceive the tiny ants

or not, but to remove ourselves at Lizbeth's first *pas de bourrée*. All the more so because the ants are the worst in the months I wear flip-flops, if I have them.

(Perhaps someone will misunderstand the above. Lizbeth does the Dance of the Zillion Fire Ants when she recognizes more fire ants than she cares to eat, not when she is being bitten. Since I have learned to react promptly, she does not get bitten at all. It is the isolated patrol of fire ants that falls in Lizbeth's range that deserves pity. Lizbeth finds them quite tasty.)

By far the best way to go through a Dumpster is to lower yourself into it. Most of the good stuff tends to settle at the bottom because it is usually weightier than the rubbish. My more athletic companions have often demonstrated to me that they can extract much good material from a Dumpster I have already been over.

To those psychologically or physically unprepared to enter a Dumpster, I recommend a stout stick, preferably with some barb or hook at one end. The hook can be used to grab plastic garbage bags. When I find canned goods or other objects loose at the bottom of a Dumpster I usually can roll them into a small bag that I can then hoist up. Much Dumpster diving is a matter of experience for which nothing will do except practice.

Dumpster diving is outdoor work, often surprisingly pleasant. It is not entirely predictable; things of interest turn up every day and some days there are finds of great value. I am always very pleased when I can turn up exactly the thing I most wanted to find. Yet in spite of the element of chance, scavenging more than most other pursuits tends to yield returns in some proportion to the effort and intelligence brought to bear. It is very sweet to turn up a few dollars in change from a Dumpster that has just been gone over by a wino.

The land is now covered with cities. The cities are full of Dumpsters. I think of scavenging as a modern form of self-reliance. In any event, after ten years of government service, where everything is geared to the lowest common denominator, I find work that rewards initiative and effort refreshing. Certainly I would be happy to have a sinecure again, but I am not heartbroken not to have one anymore.

I find from the experience of scavenging two rather deep lessons. The first is to take what I can use and let the rest go by. I have come to think that there is no value in the abstract. A thing I cannot use or make useful, perhaps by trading, has no value however fine or rare it may be. I mean useful in a broad sense — so, for example, some art I would think useful and valuable, but other art might be otherwise for me.

I was shocked to realize that some things are not worth acquiring, but now I think it is so. Some material things are white elephants that eat up the possessor's substance.

The second lesson is of the transience of material being. This has not quite converted me to a dualist, but it has made some headway in that direction. I do not suppose that ideas are immortal, but certainly mental things are longer-lived than other material things.

Once I was the sort of person who invests material objects with sentimental value. Now I no longer have those things, but I have the sentiments yet.

Many times in my travels I have lost everything but the clothes I was wearing and Lizbeth. The things I find in Dumpsters, the love letters and ragdolls of so many lives, remind me of this lesson. Now I hardly pick up a thing without envisioning the time I will cast it away. This I think is a healthy state of mind. Almost everything I have now has already been cast out at least once, proving that what I own is valueless to someone.

Anyway, I find my desire to grab for the gaudy bauble has been largely sated. I think this is an attitude I share with the very wealthy — we both know there is plenty more where what we have came from. Between us are the rat-race millions who have confounded their selves with the objects they grasp and who nightly scavenge the cable channels looking for they know not what.

I am sorry for them. 🍷

Build Homes Not Bombs

Get a Better Economy to Boot!

Richard Krushnic

Our nation has a rare opportunity to shift resources from military to civilian activities for the next few years. A budget pact is supposed to prevent transfers of funds from the military to domestic programs during fiscal years 1992 and 1993, but the pact is cracking in light of the sudden collapse of the Soviet military and the dismemberment of the Soviet Union. While jobs are lost when funds are shifted out of the military, the funds don't disappear — they are used for alternative federal expenditures, paying federal debt, or tax reduction. Many alternative expenditure patterns are available to improve the quality of life for middle-income and low-income citizens and the international competitiveness of our economy. If \$25 billion a year were shifted into affordable housing development and retention for a period of years, low- and moderate-income families and individuals would find housing to be much more affordable and available, homelessness would be greatly reduced, and overall employment and economic output in the eastern Massachusetts region would increase.

Our nation has a rare opportunity to shift resources from military to civilian activities for the next few years. The fiscal 1992 funding year, which began October 1, 1991, might see such a shift. In a few weeks Congress and the administration will probably take \$1 billion of the military budget and use it for aid to the Soviet Union. A budget pact is supposed to prevent transfers of funds from the military to domestic programs during fiscal years 1992 and 1993, but the pact is cracking, and powerful forces in the country and in Congress want the pact reexamined in light of the sudden collapse of the Soviet military, and the dismemberment of the Soviet Union.

While jobs are lost when funds are shifted out of the military, the funds don't disappear — they are used for alternative federal expenditures, paying federal debt, or tax reduction. Either way, the dollars are used for other purposes that generate jobs and economic activity. Many alternative expenditure patterns are available to improve the quality of life for middle-income and low-income citizens and the international competitiveness of our economy. The better alternatives would be marked improvements over the current alternative: too much money for the savings and loan

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bailout, the commercial bank bailout, wars (like Iraq and the Latin American "drug" wars, which are really counterinsurgency wars), and a health care system that permits unnecessary procedures, limits necessary procedures, and falls flat on preventive health care.

Shifting federal resources from the military to human services, housing, economic infrastructure, programs to increase international competitiveness, and environmental protection would increase employment and economic output and improve the quality of life. Former secretaries of Defense, many congresspersons, and numerous policy institutions have concluded that the Department of Defense and the military component of the Department of Energy should have their budgets cut in half over the course of a decade. By some measures, military spending cuts have already begun. Such a reduction amounts to roughly \$150 billion a year in current dollars. Cuts would be smaller at first but reach this level at the turn of the century or shortly thereafter.

If one sixth of that amount, \$25 billion a year, were shifted into affordable housing development and retention for a period of years, low- and moderate-income families and individuals would find housing to be much more affordable and available, and homelessness would be greatly reduced. Greater Boston Jobs with Peace (JWP) asked Boston voters in a 1987 referendum if they would like this to happen. The voters said yes and asked the city to tell them what that would mean in terms of additional housing services it could provide. The city's 1989 report in response to the JWP referendum showed how Boston's share of such a shift in spending would meet the city's affordable housing needs and increase overall employment and economic output in eastern Massachusetts as well.¹

Of course, homelessness cannot be dealt with simply by making more affordable housing available. Additional educational, employment training, counseling, advocacy, and employment opportunities must also be provided. Supportive services, abundant and less-expensive housing will not do the job unless a healthier economy produces jobs and a correspondingly healthier tax base to support the services.

Most of our tax dollars go to the federal government, and half of those to the military. The demise of the Soviet threat means that funds can be shifted to an alternative federal spending pattern. Such an alternative pattern will both meet human needs and improve the overall quality of life, including making the economy more internationally competitive so that the improved quality of life can be sustained indefinitely.

Just as in the case of the housing example, shifting spending to such an alternative pattern would result in a net increase in employment and output in New England. Massachusetts would benefit more than the other large population state in the region, Connecticut, and details of how Massachusetts would benefit are provided below.

The basic idea is contained in three principles: shifting some resources from the military to building economic infrastructure (transportation, communications), education, and programs and incentives to improve the international competitiveness of the economy will benefit the entire nation; the highly diversified, high-tech nature of the New England economy in general, and of Massachusetts in particular, predisposes the region to benefit from the new federal spending pattern; and in order to truly improve the quality of life, the shift in resources must not be only to human services, housing, and the environment, but also to the expenditures to improve the economy; otherwise the humanizing impacts will be unsustainable.

The shift will not be without pain. Some specific military facilities (parts of bases and private research and manufacturing) will not be successfully converted to civil-

ian uses. Many military employees will not find alternative employment at comparable pay or working conditions. By "military employee" I mean a full-time uniformed or civilian employee of the Department of Defense (DOD) or the military parts of the Department of Energy (DOE) and NASA, or workers in private research and manufacturing supported by military DOD, DOE, or NASA research and procurement dollars. But many military facilities and employees will come out fine. Much more important, regional benefits from increased civilian employment and output will far surpass the pain and provide jobs for many formerly in military work.

If this is what we want, we must fight for it, or it won't happen. A new military strategy that perceives (or creates) military threats from newly industrialized nations like Iraq, the savings and loan bailout, the commercial bank bailout, an unimproved health care system, and the deficit are all partially unjustifiable alternatives that are eating up the "peace dividend" as fast as it materializes. The military-industrial sector is in the midst of creating a national security paradigm to justify continued high military spending. This was one of the main reasons for the war against Iraq. We will be told that we must be prepared for a succession of Saddam Husseins in newly industrializing countries. This paradigm is unjustifiable and unsustainable. We must educate the public and scale down the national security threat to realistic proportions. The new paradigm merits rejection.

We can fight to pay \$200 billion in savings and loan bailout costs by meeting the costs sooner rather than later (by borrowing the money) and getting money back from fraudulent S and L owners, or we can continue on the present course and pay \$600 billion for the bailout over the course of the next generation. We can bite the bullet now and rationalize our health care system in an equitable manner, or we can let the costly, wasteful, and unjust drift of the health care system continue.²

The way to reduce the deficit is to use our scarce resources to make the economy stronger and more competitive. Then the economy will generate sufficient revenue to meet public expenditure requirements *and* reduce the deficit. Or we can continue to dump too much money into the military, an unrationalized health care system, and the bank bailouts, which will worsen the economy and weaken its ability to produce public tax revenue. The choices are partly in our hands. The money is there. We must set our priorities right in order to get it.

Where Is the Federal Budget Battle?

In 1991, the Budget Enforcement Act (BEA) committed the federal government to a five-year budget deal. The budget was divided into two components: mandatory (Social Security, bank deposit insurance, payments on the federal debt, and so on), and discretionary. Discretionary spending was divided into three parts: defense, foreign aid, and domestic spending. Spending caps were set for each of the three parts for each of the first three fiscal years (1991, 1992, and 1993).

The BEA enables Congress and the president to make changes within the defense budget or among the various domestic programs, but does not allow a transfer of funds from the military to domestic spending. Thus, a "budget wall" was erected to prevent transfers from military to domestic spending.

The wall is removed for the fourth and fifth years of the pact (fiscal years 1994 and 1995). There is still an overall limit for discretionary spending, but funds may be transferred from one of the three domestic components to another. Fiscal 1991

ended September 30, 1991. Debate over the fiscal year 1992 budget has been going on since early spring. The five-year BEA's deal for fiscal 1992 domestic spending is defense, \$291 billion, foreign aid, \$15 billion, and domestic spending, \$198.5 billion.³

According to the Congressional Budget Office, the administration intends to comply with the BEA's requirements for fiscal '94 and '95 by taking a slight "real" cut in defense spending and a much larger real cut in domestic programs. The administration proposes to go up from the 1992 and 1993 defense level of \$271 billion to \$295.5 billion in fiscal '94 and \$298.5 billion in '95, increases of \$4.5 billion (1.5%) and \$4 billion (1.4%).⁴ These "absolute" increases are "real" declines because price inflation reduces the value of each defense dollar more than the budget increases provided for in terms of increased defense purchasing power.

If inflation is 5 percent, the FY '94 increase of 1.5 percent is short of the 5 percent impact of inflation, and the "real" FY '94 defense budget will decline about 3.5 percent. There would be a similar real decline in FY '95. In order to maintain real level funding, the FY '94 defense budget would have to be increased not by the proposed \$4.5 billion but by \$14.5 billion.

The Congressional Budget Office continues to inform us that in order to stay within the overall FY '94 BEA budget cap for discretionary programs (defense, foreign aid, and domestic), the proposed real cut in defense (which allows for a \$4.5 billion absolute increase) would force an absolute cut of \$16.5 billion in foreign aid and domestic programs combined. The corresponding real reduction for foreign aid and domestic programs would be far larger than the absolute \$16.5 billion reduction, because the impact of inflation will make each of fewer dollars worth less. As if that weren't bad enough, the administration intends to cut foreign aid and domestic spending combined by a whopping \$24.4 billion in absolute dollars in fiscal 1995. In other words, the proposed slight real reduction in defense spending would mask an enormous reduction in nondefense discretionary spending.⁵

Remember, however, that after FY '93 the five-year pact permits the administration and Congress to shift funds from defense to domestic programs. You might ask, "Why can't Congress just reject the administration's proposal and shift additional funds to domestic programs?" The budget pact was largely sold on the argument that weapons systems development and projection were locked in by legally binding contracts to the extent that possible research and procurement cuts were very limited.

The sudden collapse of the Soviet military threat has made U.S. citizens see the defense levels in the five-year budget pact as too high. The Warsaw Pact has been dissolved, the Soviet Union has been dismembered, unilateral Soviet disarmament has continued apace, most top-secret Soviet military technology is up for sale, and even President George Bush is bowing to pressure from resurgent Europe with his unilateral stand-down from alert status for intercontinental bombers and land-based missiles. There is clearly no need to keep the high defense levels of the budget pact, yet the BEA's budget wall remains standing. The wall is under attack, however.

In fact, since the aborted summer coup in Moscow, it has become so fashionable to bash the budget pact, that Republican Housing and Urban Development (HUD) Secretary Jack Kemp said at the end of October 1991 that the pact should be abandoned for the fiscal year October 1, 1991, to September 30, 1992, and that funds should be transferred from military to domestic programs.

In mid-October, Massachusetts Congressman Barney Frank's Operation Jericho bill failed, but got a yes from a majority of House Democrats, and a total of 145

votes. Frank's bill called for an FY '92 reduction of \$11 billion in military spending, half of which would be transferred to deficit reduction (debt repayments) and half to increase domestic spending. A month before the vote on Frank's bill, liberal populist presidential candidate Senator Tom Harkin floated an unsuccessful BEA-busting FY '92 \$3 billion transfer from military to domestic spending in the Senate.

The Bush administration resisted the extension of exhausted unemployment benefits, but the president finally relented to a Congress with enough votes to override his veto in the fall of 1991. This was technically a budget pact buster, so Congress avoided the problem by funding it out of future unemployment insurance income.

Since House Speaker Tom Foley and Ways and Means Chairman Dan Rostenkowski were architects of the BEA, they are reluctant to scrap it after just one of its five years. But House Budget Committee Chairman Leon Panetta, House Majority Leader Richard Gephardt, and Senate Majority Leader George Mitchell are ready to scrap the pact. The budget wall could fall soon and even release some FY '92 funds. At this writing it may still be more likely that the pact will be voted out in fiscal '92, but that the budget won't be affected until fiscal '93.

House Budget Chairman Panetta, who is looking toward reductions in military spending on the order of 33 percent to 40 percent over the next few years, wants much of the funds shifted to education and health. Remember that even the administration is calling for a 25 percent cut during the 1990s.

In October 1991, the Brookings Institution released *Decisions for Defense: Prospects for a New Order*, which calls for a 33 percent military budget cut over the next few years. Their analysis of war-fighting needs leads them to recommend, among other things:

- Halting production of the B-2 bomber
- Reconfiguring the B-1 to a cheaper aircraft
- Deferring deployment of the small intercontinental ballistic missile
- Limiting the Trident program to eighteen submarines
- Focusing SDI on a ground-based system (much cheaper than a satellite-based one)
- Killing the new C-17 transport aircraft before any production models are built
- Delaying production of next-generation combat aircraft

The budget wall will be brought down. Substantial funds will be transferred from military to other uses. But what is to prevent those other uses from being more wasteful spending on an unrationalized health care system, an S and L bailout that makes little attempt to recover fraudulently obtained funds, or more tax breaks for the rich? There are plenty of competing uses for the peace dividend.

The problem is that, just as in Massachusetts, so many of the groups that could band together to pressure for sensible alternate uses are so busy fighting state budget cuts and other immediate battles that they don't even have the big money — the impending peace dividend — on their screens, much less a focus of their organizing activity. The sweeping changes with an impact on the national security arena are coming so fast that the constituencies which should be shaping the direction of

federal spending are going to see much of the peace dividend sail right over their heads if they don't focus significant energy on the federal budget now.

Shifting Military Spending to Appropriate Alternatives

While many would like to see a shift in federal spending out of military production and force maintenance and into other areas of spending designed to better meet domestic needs, some people fear that the loss of military production jobs will somehow leave us with an overall net negative impact on the economy and jobs. In fact, shifting resources from the military to human services, housing, infrastructure, programs to increase international economic competitiveness, and environmental protection and abatement would increase overall employment and economic output, not to mention the overall quality of our lives.

Shifting resources in this way increases employment because the nonmilitary activities receiving more funds are all more-labor and less-capital intensive. They all employ more people per billion dollars expended. Shifting resources in this way will increase overall economic output as long as the alternative spending pattern is designed to strengthen the economy.

In Massachusetts, such a shift would result in overall increased economic output, because the characteristics of the area economy would attract the alternative spending pattern's dollars. Assuming that human services and affordable housing resources would be distributed according to need, New England in general, and Massachusetts in particular, would be expected to get their population share of any such shift in federal spending. The New England region has the oldest economic infrastructure in the nation and would be expected to gain more than its population share for rebuilding such economic infrastructure as roads and bridges.

Both direct federal expenditures (investment, education, training) and indirect federal expenditures (investment tax credits) to improve international economic competitiveness would benefit New England because any such federal programs would emphasize high-tech manufacturing and highly professional and technical services. These are the economic activities that will improve the international competitiveness of regional and national economies in the future. New England in general and Massachusetts in particular are well suited to capture their share or more of such federal dollars, because these economic activities are already the strong points of their economy. The region is also well positioned to capture more than its population share of environmental protection and abatement dollars because of its strength as an innovation center for high-tech and professional services.

Among the New England states, only in Connecticut — the most military procurement-dependent state in the nation — might it take more than a few years to see a significant net improvement in the economy from such a federal spending shift. Long term, Connecticut would benefit as well from the local impact of economic improvement at national and regional levels.

While Japan and Germany turn U.S. military technological advances into commercial products that conquer the world's markets, the United States fails to capitalize on these advances of its own making. It is not merely coincidence that persistently low military spending in those countries correlates with persistently high advances in high-tech commercial markets. While they invest in processes and equipment that produce other marketable processes and equipment, we invest in

weapons systems that not only don't produce anything, but soak up additional resources to man and maintain them. As if this weren't bad enough, the United States keeps its best technical minds busy trying to figure out things like how to make communications equipment function while nuclear bombs are going off nearby, instead of figuring out how to apply new technology to mass consumer markets. For these reasons a shift of resources as outlined above will help the entire national economy, including Connecticut's.

Converting the American Economy: The Economic Effects of an Alternative Security Policy, released by Michigan's Employment Research Associates (ERA), proposes a four-year shift from military to domestic spending that starts with \$35 billion and ends with \$104 billion, for an average of \$70 billion a year. This is in the same ballpark as proposals being debated in Congress, although some congressional approaches involve a longer time frame. ERA recommends an alternative spending pattern similar to that suggested in this article. The ERA proposal is illustrated in Table 1.

The ERA estimated economic demand changes by sectors and ran its numbers through the Multi-regional Forecast Simulation Model of the Regional Economic Models, Inc. (REMI) of Amherst, Massachusetts. The results of the five-year shift were a national net employment increase of 477,000 jobs. Twenty-four thousand jobs were lost for every \$1 billion cut from the military, and nearly 31,000 nonmilitary jobs were created, a net gain of 6,800 jobs for each \$1 billion transferred (see Appendix A for breakdown by economic sector).

The ERA study includes good detailed discussions of an alternative military security policy and corresponding military reductions and the need for new expenditures in each of the alternative expenditure categories shown in Table 1.

Among others, three former U.S. secretaries of Defense, Jobs with Peace and a host of other groups in a Common Agenda Coalition, and a substantial minority in Congress have been advocating for several years that the military budget be halved from (in current dollars) the \$300 billion-a-year range to the \$150 billion-a-year range by the year 2000. For the past several years (including FY '92), military spending has been declining a few billion dollars a year. The quick war against Iraq may end up causing a one-time increase in military spending, but the consensus remains that military spending is headed down for years to come. It might head down rapidly for a few years.

Table 1

**New Program Funding, Fiscal Years 1991-1994
(in billions of current dollars)**

	1991	1992	1993	1994	Average
Education	\$ 6.4	\$10.9	\$15.6	\$ 19.5	\$13.1
Infrastructure	\$ 5.1	\$ 8.7	\$12.4	\$ 15.6	\$10.5
Environment	\$ 2.4	\$ 4.1	\$ 5.9	\$ 7.4	\$ 5.0
Housing	\$ 5.4	\$ 9.2	\$13.1	\$ 16.5	\$11.1
Social Services	\$ 4.0	\$ 6.8	\$ 9.7	\$ 12.1	\$ 8.1
Health Care	\$ 4.5	\$ 7.6	\$10.9	\$ 13.6	\$ 9.2
Civilian R&D	\$ 4.2	\$ 7.2	\$10.2	\$ 12.8	\$ 8.6
Employment & Training	\$ 2.5	\$ 4.2	\$ 5.9	\$ 7.4	\$ 5.0
Total	\$34.6	\$58.8	\$83.7	\$104.9	
	Annual Average New Spending				\$70.5

Many constituencies have never entered the battle for the federal budget, because they felt that it was an impossible battle to win and an arena inappropriate for their small organizational resources. But suddenly it has become a winnable battle. If new constituencies to this fight do not organize a national coalition quickly, however, established lobbying associations will walk away with much of the peace dividend.

The Example of Affordable Housing

If we do see military spending decline to the levels the ex-secretaries of Defense and the Common Agenda Coalition are calling for, it would not be unreasonable to see a period of five or ten years when federal spending on affordable housing would command \$25 billion a year more than it does now. That would be one sixth of the additional civilian spending made available each year by the shift of resources out of the military to alternative activities, and the remaining five-sixths could be spent on the other alternatives mentioned above.

What would a shift of \$25 billion a year into affordable housing look like? When Greater Boston Jobs with Peace took that question to Boston voters in 1987, the response was two to one for a shift from the military. In response, the Boston Redevelopment Authority (BRA) in 1989 released *From a Military to a Housing Buildup: The Impact in Boston of a Six Percent Shift in the Federal Budget from the Military to Housing*.

As shown in Table 2, the federal military budget in 1989 was \$404 billion (48% of your federal tax dollars), and the housing budget was nearly \$8 billion.⁶ Recent increases have raised the federal Department of Housing and Urban Development (HUD) budgets to the low \$20 billions, but over a third of the more recent budgets merely continues expiring rental assistance and does not indicate an increase in the level of housing programs. In 1989, the \$25 billion transfer represented a loss of 6 percent of military spending and a quadrupling of affordable housing spending. Such a shift today would more than double affordable housing spending and would nearly triple the actual level of housing services provided.

Table 2

Federal Spending on Housing and the Military, Fiscal Years 1981-1989 (in millions of dollars)

Budget Category	FY81	FY82	FY83	FY84	FY85	FY86	FY87	FY88	FY89 ²
HUD	32,201	18,908	14,290	14,088	11,747	10,456	8,395	8,635	7,851
Military	210,160	247,559	276,302	305,778	344,371	370,927	378,964	392,772	404,176
Defense Function	157,513	185,309	209,903	227,413	252,748	273,375	281,999	290,361	298,255
Int'l Security Assistance	5,095	5,416	6,613	7,924	9,391	10,499	7,106	4,500	2,823
National Aeronautics and Space Adm. ¹	—	—	1,089	534	732	770	739	909	1,068
Military Portion of Net Interest on Public Debt	47,552	56,834	58,697	69,907	81,500	86,283	89,100	97,002	102,030

1. Military activities of NASA only.

2. HUD and military budgets estimated for FY 1989.

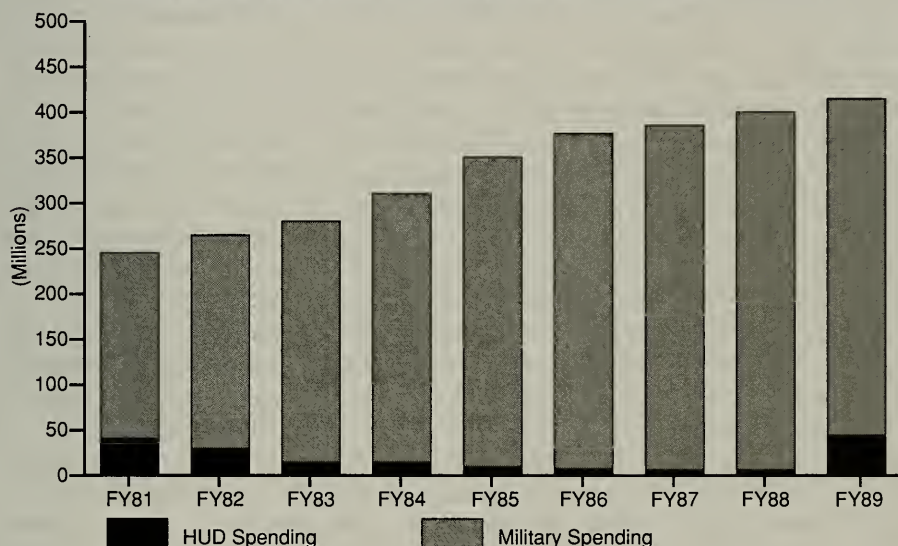
Sources: National Low Income Housing Information Service; Military Spending Research Services, Inc.

Figure 1 shows how federal housing spending declined during the 1980s while military spending increased. In real dollars, 1989 housing spending was less than one-sixth what it was in 1979. Increases over the past two years plus an additional \$25 billion shifted from military spending would still leave housing spending below 1979 levels in inflation-adjusted dollars.

The BRA study looked at current housing funds allocation formulas based on population, percent living in poverty, and other indicators of need and concluded that if the same allocation procedures were used, Boston's share of an additional \$25 billion a year nationally would provide \$153 million a year more for housing programs. This is well above the \$60 million that Boston would receive if allocation were based solely on population share. Other old, large New England cities would experience allocations higher than their population share.

Figure 1

**Military and HUD Spending, Fiscal Years 1981–1989,
with a 6 Percent Shift from the Military to HUD in FY 1989**



Sources: National Low Income Housing Information Service; Military Spending Research Services, Inc.

This \$153 million could be used by the public sector to leverage additional private housing investment and generate about 2,300 new or substantially rehabilitated housing units per year, all of which would be affordable to low- or moderate-income people, and is enough to meet Boston's housing needs. This BRA scenario is unrealistic, however, because public subsidy would never need to be so high (\$67,000/unit of housing). At most, public subsidy per unit would not have to exceed half that amount. Private funds could be leveraged to finance the rest of the housing development cost. That would leave half the funds to help low- and moderate-income people pay rent; to purchase ownership shares and turn their housing into cooperatives or reduce the monthly mortgage interest payments for new homeowners; to provide

related job training, education, and counseling to support households in precarious housing situations or those in transition from homelessness (see Appendix B).

Alternatively, as shown in the BRA study, \$106 million per year of the funds could supplement the rents of 68,000 low-income renter households in the city who now pay rents in excess of 30 percent of their gross incomes. This would leave \$47 million, which could leverage additional private funds to generate 1,400 new or substantially rehabilitated housing units per year.

This kind of housing is already being created in thousands of communities across the United States. Typical development arrangements include establishment of project specifications and objectives by public-private partnerships between a community and a nonprofit or for-profit developer, with support from additional philanthropic or below-market-rate private financing. The community packages local, state, and federal development subsidy funds into the project, and private financing sources put up the majority of the total development cost.

The result is mixed-income rental housing with the poorest tenants receiving ongoing rental assistance (part of the rent being paid with public funds); or cooperatives, for which public funds pay the bulk of the cost for low-income tenants to purchase ownership shares; or homeownership, for which public funds keep closing costs and down payment low for the buyer, and pay part of the buyer's mortgage interest.

Currently, all New England states have federal Section 8 funds that provide exactly this rental assistance service for some of their low-income households. Massachusetts has the 707 program, which is a mirror image of the federal Section 8 program but uses state funds. The Massachusetts legislature has cut \$33.5 million a year in 707 rental assistance. If \$25 billion a year for five or six years were shifted to housing and related programs, Massachusetts's share would be about \$700 million a year. The state would never have to think about cutting rental assistance.

The BRA study figured that a \$25 billion shift from the military to housing would bring an additional \$375 million into the Greater Boston area extending out nearly to Route 495 (the area included in the BRA's regional economic computer model). Their model took into account the jobs that would be lost in the military sector, including private manufacturing and research, and showed a 7,400 net increase in jobs when all the funds were spent in housing development. The additional jobs were in construction and the making, selling, and transporting of housing materials from lumber to paint to refrigerators. The model also indicated that there would be a net increase in regional personal income of \$147 million a year.

Similar comparisons could be made regarding shifts in spending from the military to the other areas suggested above: human services, economic infrastructure, programs to increase international economic competitiveness, and environmental protection and abatement.⁷ Similar results would be obtained, showing net increases in the quality of life, employment, and economic output.

This is not to say that some displaced workers in the military sector would not suffer. Some of the shifted funds would, of course, be available to assist idled military research and production facilities in adapting to the production of alternative goods and services. Assistance would be available to subsidize conversion of closed military bases to alternative uses. Resources would be available for retraining. Still, some people and some urban areas would be hurt. The region as a whole, however, would clearly benefit.

Impact on Homelessness of the Shift of Additional Resources

One way or another, all the institutions and advocacy groups involved in the issues of homelessness, affordable housing, and human services are talking about the use of public resources to improve the quality of life for the poorer portion of the population. In our economic and political system, these public resources come mainly from taxation of privately owned economic activities. Some public resources come from the recycling of publicly expended dollars as those dollars turn over again and again, rippling through the economy and generating jobs and income. But most public resources come from the private sector. We can't have the level of public resources that are necessary to meet human needs unless the private economy is healthy and vigorous.

Homelessness will not be dealt with unless the U.S. government intervenes with programs and tax breaks designed to make our economy more competitive internationally, and part of that is rebuilding economic infrastructure. Only a healthy economy can afford the public expenditures required to provide a decent quality of life for all its citizens.

Shifting funds from the military to human services and housing might help a lot of people in the short to medium term, but such high spending could not be sustained for long unless the vigor of the overall economy is improved. So in the long run it is just as important for homeless people that military funds be shifted to activities specifically designed to improve the economy as it is for funds to be shifted to programs that directly benefit them.

Even with a shift of funds to programs that directly benefit homeless people, there is a trade-off between meeting immediate and midterm need. If all the funds that have gone into shelters and hotels for the homeless had gone into transitional housing programs with related job training, education, and counseling programs, there would be far fewer homeless people today. Of course, the immediate needs of the homeless must be addressed as well. Nonetheless, more of the scarce resources available over the past decade should have been spent on transitional programs than was the case.

Certainly when we contemplate an alternative federal spending pattern that better meets the needs of our society and the world, we want to maximize the mainstreaming of homeless and near homeless people, not increase their warehousing in shelters or hotels.

More funds for housing can increase the availability of affordable single-room-occupancy (SRO) housing; group transitional housing facilities with supportive training, education, and services; housing for homeless people with special needs such as mental health or retardation problems, with related supportive services; and more affordable conventional family housing. All these programs exist in most of New England, and they should be expanded with a small share of the resources that must be shifted from military spending. But we must also insist that funds be shifted from the military to programs that improve the economy. One does no good in the end without the other. Without the latter, the transition from homelessness to a self-sustaining life of good quality will never happen, because the sustaining employment won't be there.

Impact of the Shift on Massachusetts

Military Taxes and Jobs

New England taxpayers send over half their city, state, and federal tax dollars to the federal government. They send four to five times as many dollars to the federal government as they do to state government. The federal government uses 48 percent of its tax dollars on the military, mostly to fund the Department of Defense's (DOD) operations, research and development, and weapons procurement. But some military funding goes to the Department of Energy's (DOE) nuclear weapons production, to the military component of NASA, and to pay the military's share of the national debt.

Over the past decade the federal government reduced the share of federal spending for nonmilitary purposes and transferred every dollar taken from those programs to the increased military budgets of the decade. The greatest reduction was in housing and community development programs. Those transfers paid for most, but not quite all, the decade-long military buildup. The rest was paid for by borrowing money — by the deficit. But even so, most of the deficit could have been avoided if tax reductions for the wealthy had not been enacted by the Reagan administration and Congress.

There are no exact measures for direct or indirect military employment. Jobs with Peace estimates that Massachusetts military employment peaked in 1988–1989 and has subsequently declined by about 2 percent. There are about 120,000 direct and indirect military jobs in the state, comprising 4 percent of the state work force.⁸ Direct employees are civilians in private firms doing work under military contracts or military personnel or civilians directly employed by the DOD. Indirect employment includes suppliers of goods and services to these private military contractors and DOD facilities. Examples are sheet metal or office supply producers who sell to military contractors, subcontractors, or military bases.

Massachusetts Direct and Indirect Military Employment

	Jobs Direct	Jobs Indirect	Total
DOD R and D and procurement in private firms	59,000	30,000	89,000
DOD civilian and military employees	21,000	10,000	31,000
Totals	80,000	40,000	120,000

Anticipated reductions in military spending could occur in three areas: operations/force levels, research and development, and procurement/production of military hardware. Massachusetts has relatively small forces based in the state, but its largest facility, Fort Devens, is slated to be closed and converted to civilian uses.

Since Massachusetts has the highest proportion of its defense contracting awards in research and development among all the states, and since R and D is not expected to be cut appreciably, the state should continue to do well in that area. Reductions in missile, radar, and jet engine procurement, however, will cost the state several thousand jobs over the coming decade.

Massachusetts gets less than its population share of military spending in operations — the largest category — because its per capita receipt of military base dollars

is below average. There are approximately 21,000 direct DOD uniformed and civilian employees in Massachusetts, and about 10,000 indirect jobs generated by this direct employment. In the spring of 1991, DOD announced that Fort Devens would be closed, and the decision has subsequently become final. Congress had decided in 1988 to expand the base with a new mission. That decision, which had the force of law, has been reversed. The Devens closing may eliminate up to 9,000 of the state's 21,000 direct DOD employee jobs and 4,000 of the 10,000 indirect jobs that the direct jobs generate.

Massachusetts gets more than its share of R and D and procurement dollars and is one of the nation's leading military contracting states. Virtually none of these military contracting dollars goes to companies or universities in Boston. The bulk of it goes to firms and schools in the area between Route 128 and Route 495. Worcester is strong in airframe forgings and aircraft and missile ceramics. Western Massachusetts has missile guidance and a variety of subcontracting, largely from Connecticut military contractors. But these areas are less dependent on military employment than the Routes 128-495 belt. Boston itself has virtually no direct and little indirect military employment. The city's economy has benefited to some extent from the general level of economic activity that military employment has brought to the eastern Massachusetts region.

Military Employment in Perspective

Let us place military employment in proper perspective. For many years the printing and publishing industry in Massachusetts employed about as many people as military R and D and production. Even after the recent decline in the minicomputer industry, computer hardware and software for civilian markets employ more than military R and D and production, and public and private employment in education is four to five times greater.

Massachusetts lost 125,000 jobs in 1990 (4.1%) from all employment sectors combined, more than the combined total of all direct and indirect military employment, of which only 1,000 or 2,000 were military. That loss, the sharpest one-year percentage drop since such records have been kept, exceeds the 1.1 percent and 3.4 percent losses in the 1982 and 1974 recessions, respectively. New England's 1990 loss from all employment sectors was 250,000 jobs, about the same number as the total direct and indirect New England military employment.⁹

The point is that Massachusetts in particular, and New England in general, are highly diversified, high-tech-oriented economies in which military jobs play an important, but quite minor role. Over 20,000 jobs have been lost in the Massachusetts minicomputer industry over the past three years because personal computers, largely made elsewhere, have been expanding in power and eating into the Massachusetts share from the bottom of the market.

Even if the DOD budget is cut in half — in inflation-adjusted dollars — over the next decade, most of the reduction in Massachusetts will be in operations, followed by procurement, and least in R and D. The resultant loss in direct military employment wouldn't necessarily exceed the loss in minicomputer jobs in the past three years. The problem is how to keep the regional economy competitive as a generator of new, high value-added high-tech industry and professional services. If this is accomplished, any reasonable alternative federal spending pattern will benefit the region.

Current federal budget priorities mean that Boston residents who could be employed in expanding high-tech commercial businesses remain unemployed or underemployed in lower-paying service jobs. Current federal budget priorities result in forgone economic opportunities — economic opportunity costs — to the entire state of Massachusetts that would easily generate more jobs and income than the jobs and income which would be lost by a substantial shift of military to civilian spending.

The net impacts of a shift of federal resources can be estimated with any degree of probable accuracy only if specifics are used — a specific amount of dollars per year from each of the three military spending categories to a specific amount into each of the alternative categories of civilian production. A detailed example is beyond the scope of this article, but if, say, \$35 billion a year from current levels of military spending — taken two-thirds from operations and one-third from production — were shifted into a spending pattern that in some way equally distributes the money among the alternative categories suggested, it is safe to surmise that such a transfer would, on balance, result in at least some net economic benefit to the state in terms of employment, income, and economic output. Depending on the specifics, the net benefit could be quite substantial.

Conversion of Fort Devens to Alternative Use

The Fort Devens closing may eliminate up to 9,000 of the state's 21,000 direct DOD employee jobs (43%), and 4,000 of the 10,000 indirect jobs (40%) they generate. Direct and indirect jobs generated by Fort Devens economic activity total 14,000, nearly 12 percent of the Massachusetts total, which includes research and production employees at private firms. The Ayer Chamber of Commerce breaks down the 9,000 direct employment estimate at 5,200 military and 3,800 civilian DOD employees.

It looks as though the base will be converted to non-DOD use with a significant minor share of the land remaining with the army for a testing/training ground, or that the entire base will be converted to non-DOD uses. It is one of three sites in the state being studied for the state's second-largest civil airport. The history of economic conversion of military bases indicates that even if the base is closed, alternative uses will generate significant employment. While the range of possibilities is large, it is quite reasonable to anticipate that reuse would generate three quarters of former employment levels within a decade. Local examples of military base reuse are the South Boston Army Base, converted into a marine industrial park, and the Charlestown Navy Yard, converted into housing, office, tourism, and retail uses.¹⁰

As the base is phased out and alternate uses begin to come in, there will still probably be a temporary dip for a few years where there might be only four or five thousand direct and indirect jobs generated by activity at the site. Over the course of the next decade, there are likely to be reductions in military and civilian employment at other military bases in the state. The air force announced at the end of May 1991 that it will reduce employment at its Hanscom Field Electronic Systems Division by 10 percent. The Weymouth Naval Air Station will be cutting a small number of jobs. These are relatively small losses in jobs, but typical of the kinds of reductions we may see a little more in the next few years.

The 9,000 Devens jobs equal about 40 percent of those which have been lost in Massachusetts mini- and mainframe computer manufacturing firms in the past four years. It helps to maintain perspective by reminding ourselves of such facts as: Massachusetts private universities and K-12 public education facilities *each* employ

about 100,000. Public colleges and private K-12 institutions employ roughly another 100,000. These 300,000 direct education jobs in turn generate about 100,000 indirect ones. The loss of Devens is a terrible blow, but there is a lot going on in Massachusetts, and there are a lot of jobs — close to 3 million of them.

Unfortunately, redevelopment of Devens in a weak regional economy is bound to be slow. The uncertainty of whether all or only part of the land is going to be released by the army makes the job harder. If the army retains part of the vast acreage to use as a mortar firing range, it would lower the value of surrounding land. Even more troubling is the extensive toxic pollution in scattered sites around the base. It is the army's responsibility to do the cleanup. Until cleanup is under way and there is certainty about its timely completion, alternate use development cannot proceed very far. It is incumbent upon all organizations in the state committed to influencing the issues discussed in this article to assist the Fort Devens redevelopment effort in putting pressure on the army to reach a final decision on the land use and to undertake significant cleanup quickly.

As for thirty years, there are federal programs to assist military base conversions. At the state level, Massachusetts created the Massachusetts Government Land Bank in 1975 to help finance military base conversions and other community development activity. The Land Bank, which had success with those conversions, currently has \$20 million in loan funds available, much of which could help finance Devens projects. The Land Bank will provide expertise and a guiding hand as well as money. Governor William Weld has established an advisory commission for Fort Devens conversion, and area communities and institutions have formed a redevelopment coalition.

The project will be a tough one in the short run, but will probably work out all right in the long run. In a study that understated difficulties and long time frames, the DOD Office of Economic Adjustment did a 1986 survey of 97 closed military bases that employed 93,000 civilians. After conversion to non-DOD use, they employed 158,000 civilians. As with the Boston Army Base, 75 include industrial parks, 42 have municipal airports, and many have schools.

State Activity for Alternate Use

State governments and other public and private institutions at the regional and local level can initiate steps to ameliorate the negative impact of military cuts and enhance the positive impact of alternative federal spending. Regions should undertake activities that will attract public and private dollars which are no longer claimed by military activities. The Land Bank, a perfect example, reduces the negative impacts of base closings by helping to plan and finance reuse.

The Bank of Boston's Economics Department released its "Survey of New England Defense Contractors" in 1990. The 355 respondents were predominantly small and well-established firms, three quarters of which were manufacturers and the remainder largely service providers. Eighty percent had sales of \$25 million or less. Defense contracts account for over 40 percent of sales, on average. When asked which type of government support they preferred to help them adapt to reduced military contracts — grants, loans, export assistance, or worker training — 56 percent of the respondents picked export assistance, grants and loans each received about 25 percent, and worker training 20 percent. Overseas markets accounted for a significant chunk of the firms' sales, especially in Massachusetts, where foreign sales are 25 percent of total sales. Not only are foreign sales strong, but the firms think

foreign sales are a key to growth. Export controls and lack of depth in export experience are limitations.

Redirected federal dollars could respond to this need and export controls could be further relaxed. But states don't have to wait for the federal government to respond. State resources could be directed to help these firms develop export markets, which in turn would demonstrate the profitability of New England high-tech export-oriented business and attract further investment into the region.

A Winning Strategy

The savings and loan bailout could cost the taxpayers between \$200 billion and \$600 billion from its beginning in 1989 and continuing for a generation.¹¹ If we paid more of the bailout cost over the next few years, rather than stretching it out, we could cut the \$600 billion in half. Congressman Joseph Kennedy's bill, which has made it out of committee in the House, proposes this correct pay-now approach. If Kennedy's bill were to be adopted, and if the Congress and the judicial system went after perpetrators of fraud in the S and L industry, the cost could be further reduced, by recovering some of the funds, to no more than \$200 billion. If advocates of alternative spending patterns direct all their energy toward dealing with municipal and state fiscal crises and never focus on the federal budget, the cost of the bailout will be closer to \$600 billion than \$200 billion. It is partly up to us whether money freed by reduced military spending goes to waste in this bailout or to humanizing and economically productive uses that will strengthen the economy and improve the quality of life.

The deficit is the military budget. As previously noted, the 1980s saw every federal dollar cut from nonmilitary programs transferred to the military. In addition, federal taxes on the wealthy were reduced. The combined effect caused the deficit to multiply astronomically. The most efficient and painless way to reduce the deficit is to improve the productivity, innovation, and competitiveness of the economy. This will increase public revenues sufficiently to maintain adequate spending levels *and* reduce the deficit. If more tax dollars had been used in the 1980s for economic infrastructure, education, and other programs and incentives to improve the economy, we wouldn't have the deficit problem today. Again, the choice is partly ours, to the extent that we educate ourselves about what is necessary to improve the economy and be advocates for it, so we can get what we want.

The winning strategy fuses the energies of constituencies that want to reduce military spending; human services, housing, education, and environmental constituencies that want to maintain or strengthen public expenditures and laws; and business, labor, and policy groups who understand that a healthy, competitive, profitable, and relatively full employment economy can be attained only if federal resources are shifted toward economic infrastructure, education, and programs and incentives to increase economic competitiveness.

Human services, housing, and environmental groups must develop and demonstrate an understanding of the economic realities that make their demands realistic and sustainable. They must not just be advocates for their constituents' immediate requirements, but must also advocate public spending that will improve the economy and make their humanizing demands sustainable.

Business, labor, and policy groups who have restricted their advocacy to narrow economic issues must respond to the new economic sophistication of the human ser-

vice organizations, and realize the wisdom of forming an alliance with them. These progressive business groups must add arguments for the quality of life to their narrow economic perspective. Peace and disarmament groups must recognize that their objectives can best be accomplished by demonstrating to the human services and business groups that the resources needed to accomplish their objectives can largely be found in the military budget.

Peace constituencies must spend much more time doing this and much less pointing out what is wrong with persistently high military spending in terms of destructive foreign policy and the threat of nuclear war. Only with this more sophisticated understanding and strategy can these three constituency groupings achieve their respective objectives — together. 🐼

Appendix A

Occupational Employment Impacts of Alternative Priorities

(Average Annual 1991-1994)

Net Gain Occupations	Jobs Lost from Military Spending Cuts	Jobs Gained from Civilian Spending Increases	Net Jobs Gained or Lost
<u>Managerial & Management Related Occupations</u>			
Educational administrators	-1,300	+7,850	+6,550
Financial managers	-7,190	+18,120	+10,930
Public administrators	0	+1,240	+1,240
Purchasing managers	-2,230	+3,120	+890
NEC* other managers	-62,400	+107,370	+44,970
Accountants & auditors	-14,670	+25,980	+11,310
Inspectors, management	-3,320	+3,650	+330
Insurance claims examiners	-220	+400	+180
Wholesale & retail buyers	-1,240	+1,860	+620
NEC other management support	-31,240	+42,030	+10,790
<u>Engineering Occupations</u>			
Chemical engineers	-990	+1,620	+630
Civil engineers	-3,120	+9,740	+6,620
Electrical & electronic engineers	-12,770	+13,220	+450
Mechanical engineers	-6,910	+8,000	+1,090
Mining petro engineers	-330	+790	+460
Architects	-1,080	+3,230	+2,150
Surveyors	-1,640	+3,470	+1,830
<u>Computer, Natural, Mathematical & Social Scientists</u>			
Computer systems analysts	-7,620	+12,220	+4,600
Natural scientists	-6,750	+9,560	+2,810
Math scientists	-1,920	+2,960	+1,040
Social scientists	-2,040	+4,120	+2,080
<u>Social, Educational, & Religious Workers; Lawyers & Judicial Workers</u>			
Clergy & religious directors	-3,330	+32,510	+29,180
Social & recreation workers	-3,940	+34,620	+30,680
Lawyers & judicial workers	-6,150	+14,330	+8,180
Pre-K, K-6 teachers	-8,730	+81,970	+73,240
7-12 teachers	-4,740	+44,010	+39,270
Postsecondary education teachers	-2,940	+11,230	+8,290
NEC teachers, counselors, instructors	-7,690	+44,290	+36,600
Librarians	-1,120	+4,640	+3,520
<u>Health Diagnosing & Treating Occupations</u>			
Physicians & dentists	-5,870	+13,370	+7,500
Nurses, dieticians, therapists	-11,790	+38,110	+26,320
<u>Writers, Artists, & Entertainers</u>			
Reporters & writers	-3,370	+4,980	+1,610
Public relations	-1,120	+3,410	+2,290
NEC writers & artists	-6,600	+14,360	+7,760
<u>Technicians</u>			
Health technicians	-11,260	+35,640	+24,380
Drafters	-5,620	+9,910	+4,290
Physical & life science technicians	-3,650	+3,980	+330
NEC technicians	-30,420	+33,880	+3,460

Net Gain Occupations	Jobs Lost from Military Spending Cuts	Jobs Gained from Civilian Spending Increases	Net Jobs Gained or Lost
<u>Marketing & Sales Occupations</u>			
Real estate agents & brokers	-2,720	+5,060	+2,340
Securities & financial sales workers	-1,130	+1,740	+610
NEC marketing & sales workers	-85,610	+138,210	+52,600
<u>Secretaries, Typists & Administrative Support Occupations</u>			
Adjusters, investigators, collectors	-6,510	+10,220	+3,710
Office machine operators	-10,780	+16,020	+5,240
NEC administrative support occupations	-191,990	+253,820	+61,830
Secretaries, stenographers, typists	-50,330	+109,170	+58,840
<u>Service Occupations</u>			
Cleaning workers	-32,610	+69,390	+36,780
Food service workers	-56,300	+98,950	+42,650
Health service workers	-11,330	+44,330	+33,000
Personal service workers	-11,350	+43,420	+32,070
Private household workers	-4,730	+7,150	+2,420
Protective service workers	-17,790	+42,750	+24,960
NEC service workers	-6,500	+13,790	+7,290
<u>Agriculture, Forestry & Fishing & Related Occupations</u>			
Agricultural supervisors	-300	+490	+190
Animal caretakers	-5,150	+15,050	+9,900
Farm managers, operators & workers	-3,470	+10,210	+6,740
Fishers, hunters, trappers	-140	+430	+290
Forestry & logging occupations	-1,380	+2,070	+690
NEC agricultural workers	-1,110	+1,780	+670
Blue-collar Supervisory Occupations	-23,970	+34,610	+10,640
<u>Construction Trades</u>			
Electricians	-6,410	+19,060	+12,650
NEC construction trade workers	-22,800	+101,840	+79,040
Extractive workers	-2,350	+4,650	+2,300
<u>Mechanics, Installers, & Repairers</u>			
Communications equipment workers	-1,170	+1,390	+220
Electric, & electronic equipment workers	-8,270	+8,840	+570
Machinery workers	-19,230	+30,560	+11,330
Vehicle equipment workers	-15,500	+19,540	+4,040
NEC mech. installers, repair workers	-11,440	+17,970	+6,530
<u>Precision Production Occupations</u>			
Precision food workers	-1,720	+2,630	+910
Precision printing workers	-890	+2,020	+1,130
Precision textile workers	-1,830	+2,520	+690
Precision woodworkers	-1,910	+3,310	+1,400
NEC precision workers	-2,750	+3,740	+990
<u>Machine Setters, Operators, Tenders; Assemblers; Plant & System Occupations</u>			
Printing workers	-4,060	+7,500	+3,440
Textile workers	-6,980	+9,040	+2,060
Woodworking machine operators	-1,340	+2,700	+1,360
NEC machine operators	-18,870	+22,440	+3,570
Plant & system occupations	-2,540	+4,390	+1,850

	Jobs Lost from Military Spending Cuts	Jobs Gained from Civilian Spending Increases	Net Jobs Gained or Lost
Net Gain Occupations			
<u>Transportation & Material Moving Machine & Vehicle Operators</u>			
Motor vehicle operators	-29,430	+54,240	+24,810
Rail transport workers	-890	+1,130	+240
NEC transportation workers	-13,570	+26,500	+12,930
Helpers, laborers & material movers	-46,360	+89,700	+43,340
Net Loss Occupations			
<u>Engineering Occupations</u>			
Aero & astronautical engineers	-4,170	+1,230	-2,940
Industrial engineers	-3,700	+3,180	-520
Metallurgists	-660	+530	-130
Nuclear & NEC engineers	-8,840	+8,120	-720
<u>Technician Occupations</u>			
Engineering technicians	-18,430	+13,650	-4,780
<u>Precision Production Occupations</u>			
Precision metal workers	-20,630	+15,220	-5,410
Inspectors, testers, graders	-13,500	+8,730	-4,770
<u>Machine Setters, Operators, Tenders; Assemblers</u>			
Numerical control machine operators	-1,670	+580	-1,090
Combination machine tool operators	-19,150	+10,860	-8,290
Metal & plastic machine operators	-11,150	+7,820	-3,330
Assemblers	-52,910	+33,620	-19,290
<u>Transportation & Material Moving Machine & Vehicle Operators</u>			
Pilots & flight engineers	-1,310	+960	-350
Water transport workers	-750	+430	-320
Uniformed Military Personnel	-498,520	+0	-498,520
Net Jobs Gained			+477,000
by \$70 billion a year transfer from military to domestic spending			

Source: *Converting the American Economy*, Employment Research Associates, Lansing, Michigan.

*NEC = not elsewhere counted

Appendix B

The Rent Gap: Boston Tenant Rent Payments over 30 Percent of Income, 1988¹

Household Income ²	Monthly Rent Affordable ³	Actual Average Monthly Rent ⁴	% of Renter Households in Income Range ⁵	No. of Renter Units in Income Range ⁶	Per Household, Gap, Monthly ⁷	Per Household Gap, 1988	Total Gap, 1988 ⁸
\$10,000	\$125	\$373	22%	27,170	\$248	\$2,976	\$80,857,920
\$10,000-24,999	\$438	\$489	33%	40,755	\$52	\$618	\$25,186,590
\$25,000-39,999	\$813	\$514	20%	24,700	\$0	\$0	\$0
\$40,000+	\$1,500	\$700	25%	30,875	\$0	\$0	\$0
Total			100%	123,500			\$106,044,510

1. Non-Boston Housing Authority tenants.
2. From BRA 1985 Household Survey; trended to 1988 using wage data from Bureau of Labor Statistics.
3. Assuming each household pays 30 percent of its income toward rent.
4. From BRA 1985 Household Survey; trended to 1988 using rent data from survey of *Boston Globe*—advertised rents by Michael Stone, University of Massachusetts at Boston.
5. From BRA 1985 Household Survey.
6. Total number of 1988 rental units estimated using data presented in Rolf Goetze, Boston's Housing Stock 1970-2000 (BRA, December 1987).
7. Actual rent minus affordable rent.
8. Annual gap times number of households.

Subsidy Required to Build Low- and Moderate-Income Units, 1989

	Moderate- Income	Low- Income
Family income ¹	\$34,000	\$23,450
Monthly cost affordable to family ²	\$850	\$586
Monthly mortgage payment	\$649	\$403
Mortgage insurance ³	\$21	\$13
Property taxes ⁴	\$66	\$66
Residential exemption	(\$12)	(\$12)
Hazard insurance ⁵	\$26	\$16
Condominium fee	\$100	\$100
Housing unit price affordable to family ⁶	\$82,200	\$51,000
Construction cost ⁷	\$100,000	\$100,000
Per-unit subsidy needed	\$17,800	\$49,000

1. U.S. Department of Housing and Urban Development.
2. Assuming family spends 30 percent of its income on housing.
3. Mortgage amount times 0.0034.
4. Construction cost times 0.01077.
5. Mortgage amount times 0.004166.
6. Assuming a 10 percent down payment and a thirty-year mortgage with a 10 percent interest rate.
7. Assuming no land costs.

Source: From *a Military to a Housing Buildup: The Impact in Boston of a Six Percent Shift in the Federal Budget from the Military to Housing*, Boston Redevelopment Authority, August 1989.

Appendix C

Critique of Typical Approach to Military Economic Analysis for New England

Dartmouth's Richard Barf contributed the piece on New England, "Living by the Sword and Dying by the Sword? Defense Spending and New England's Economy in Retrospect and Prospect," in *The Pentagon and the Cities* (Andrew Kirby, ed., *Urban Affairs Annual Review* 40 [Newbury Park, Calif.: Sage, 1992]). Typical of most articles on military economics in New England that have appeared within the past decade, this one overstates the military dependence of the regional economy, creates the impression that "defense-related" industries do more military work than is the case, fails to point out the economic benefits to the region of a shift of military spending to alternative uses, and fails to state clearly the overarching nonmilitary strengths of the regional economy. While useful in many respects, such articles do a disservice by exaggerating the negative impact of military cutbacks and understating the positive impact of alternative federal spending patterns.

In "Living by the Sword," Barf says, for example, that military prime contract awards (for research and production) to businesses accounted for more than 7 percent of Massachusetts gross state product (GSP) in 1984. This implies that direct employment on military contract work accounted for 7 percent of gross domestic product (GDP). No study has ever shown that direct military contracting employment approached anywhere near this amount.

Defense-related industry, which produces primarily for civilian markets, approaches 7 percent of Massachusetts GDP, but the military component of defense-related output is a minor share of that 7 percent. "Direct" and "indirect" military employment was estimated by Data Resources, Inc. (DRI), at nearly 7 percent, but at least one third of that is indirect economic activity — sales by suppliers of sheet metal, stationery, wire, paper clips, construction services, and so forth, to military contracting firms. Furthermore, the DRI figure included not just private military contracting, but also military bases. Jobs with Peace estimated direct and indirect military output, including military bases as well as private military contracting, at 5 percent of Massachusetts GDP.

Barf says (page 92) that the "defense share of total private employment (in Connecticut) exceeds 9 percent." This implies that all 9 percent are in defense work. He accidentally corrects himself on the next page by stating it correctly as defense-related, and not as defense, as he had done on the previous page. To qualify as a defense-related industry, at least 10 percent of the employees in the industry must be working on military projects. Thus the two statements I have cited above represent estimates that could be as much as 90 percent different from one another, depending on whether "defense" or "defense-related" is the criterion.

Barf briefly explains at the beginning of the article that defense-related means that at least 10 percent of employees are working on military projects. He never mentions this again in the article, which is entirely based on defense-related, not defense, job and output data. The way he uses the figures, plus these two clear misstatements, give the lay reader the impression that defense-related essentially means "defense." This is also true of most articles on the subject of military economics in New England over at least the past decade.

The implicit overstatement of military employment/output is magnified in Barf's article by the dearth of meaningful discussion about nonmilitary strengths of the New England economy and his concluding statement that "in the context of the present regional recession outside of defense-related industry, the prognosis for the regional economy for the next decade is not bright."

Barf's misrepresentation is nicely put in the title, "Living by the Sword and Dying by the Sword?" Barf overstates the defense component of the New England regional boom of the late 1970s and early 1980s and the contraction in defense work as a cause of the regional recession of the late 1980s and early 1990s.

He points out that between 1977 and 1984, New England defense-related industry grew 12.7 percent, four times faster than in the nation as a whole. He adds that military prime contract awards for research and development (R and D) and production increased 180 percent in real terms in New England between 1977 and 1984, the highest per capita increase in the nation. Further, Barf cites Lynne Brown, the Federal Reserve Bank's economist, who states that during this period New England was the most defense-oriented census region in the United States, with Connecticut the most defense-oriented state in the nation, New Hampshire the third, and Massachusetts the sixth.

Aside from citing Brown's observation that Massachusetts, New Hampshire, Vermont, and Connecticut also had very strong civilian components in their defense-related industries, Barf glosses over the nondefense component of defense-related industries. Again, this is typical of the entire literature. My own estimate is that 15 percent of defense-related industry employment in Massachusetts was military at the military employment peak in the mid-to-late 1980s.

Comparing 25,000 jobs lost in the past five years in the nondefense-related computer hardware industry with about 3,000 lost in military industry illustrates that the regional recession through 1990 had little or nothing to do with military spending cutbacks: I estimate, based on statements of many leading Massachusetts computer firms, that 4 percent of computer hardware and software production in Massachusetts is military, and 96 percent is for the civilian market. Hence, information/data processing systems is not a "defense-related" industry.

In Massachusetts, where the vast majority of New England's computer industry is located, roughly 25,000 computer hardware production jobs (my estimate) have been lost in the past five years. These jobs represent 44 percent of total direct defense employment in the mid-1980s, according to Jobs with Peace's *Massachusetts and Its Military Industry* (1986). Data Resources, Inc., which estimates military employment as a bit higher than Jobs with Peace does, would place 25,000 lost computer industry jobs as about one third of the total commonwealth direct military employment in the mid-1980s. Over the same five-year period when those computer hardware jobs were lost, I have heard of about 3,000 military industry jobs being cut.

Barf cites Harrison and Kluver's statement that a slowdown in the rate of growth of defense spending probably contributed to New England's poor job performance related to the nation as a whole in the late 1980s. Barf also notes that from 1984 to 1987, New England lost 8,400 defense-related jobs. Note that this tells us absolutely nothing about how many of these jobs were actually defense jobs. During the same period, 100,000 manufacturing jobs were lost. Again, the layman gets the impression that military cutbacks contributed significantly to the regional recession, when the numbers actually state the opposite. At the most, a minority of the 8,400 defense-related jobs were actually defense jobs, of a total of 100,000 jobs.

Prime contract awards (R and D and production awards of \$25,000 or greater) to R and D, engineering, and manufacturing entities peaked in New England in 1986, but remained near the peak for two more years. The funds represented in prime contract awards are expended in most cases over one to three years following the award. Hence, actual defense R and D and production economic activity did not begin to decline meaningfully in New England until 1990 at the earliest.

The regional recession that began in 1988 and may bottom out in the first half of 1992 was caused almost entirely by contraction in real estate and related construction,

finance and insurance, mini- and mainframe computer hardware, and the regional impact of the national recession. Military industry, in fact, continued to bolster the regional economy during this period.

To be sure, as Barf concludes, the regional economy is currently weak and in recession, and any substantial defense downturn will certainly make problems worse. The regional recession we have seen to date, however, has not been caused at all significantly by military cutbacks.

Military cuts will soon begin to take their toll, however. While New England had relatively low per capita annual military base expenditures, much of what it had is packing up and leaving. The supposedly nonpolitical base closings that were announced are hitting Democratic districts far harder than Republican ones. Pease Air Force Base in New Hampshire is closing. Fort Devens, Massachusetts's largest base, will be phased out over the next two years. Maine's Loring Air Force Strategic Air Command (SAC) B-52 bomber base will be closed soon. In addition, there will be a lower level of military contracting in jet engines, avionics (airplane control systems), air-to-air missiles, radar, and nuclear missile guidance and control for at least a decade.

The main impact of military R and D and production on the New England economy has always come from the R and D component, not from the direct, or even indirect, employment benefits, but rather from the spin-off of civilian industry and the general contribution to the high-tech resource base. The Massachusetts Institute of Technology-centered R and D made New England a leader in the following civilian businesses: computer hardware and software, jet engines, avionics, airframe structural members, radar, missile guidance and control, communications equipment, high temperature ceramics, lasers, and other high-tech enterprises. In large part because of military R and D, the region in general, and Massachusetts in particular, has become good at starting new high-tech businesses and nurturing them through to the beginnings of maturity, at which point they often leave New England in search of cheaper labor or location in market centers.

So the key impact of the ongoing shift of federal spending out of military production does not have to do with military cutbacks, but with the alternative federal expenditure pattern that is simultaneously emerging. Military R and D is not expected to be cut as much as other military spending categories, and Massachusetts gets the highest per capita share in the nation. So even the cuts bode better for Massachusetts than for other military-dependent states.

So far the region has been hurt more by the emerging federal spending pattern than by military cutbacks. The savings and loan bailout has captured just about all the funds that have been shifted out of military spending to date. Very little of that money goes to New England; it basically goes to the South and West.

The issue is how we can influence the alternative spending pattern to help New England use its unusually creative and skilled work force to develop and nurture growth industries.

Appendix D
Military Base Conversions

Charlestown Navy Yard

During World War II, 50,000 people worked in the 130-acre Charlestown Navy Yard cranking out small submarines and destroyers. Most of these were mothballed immediately after the war, and the yard became a maintenance and repair facility. Gradually this work became a backwater operation for the navy, but the preoccupations of the Cold War led the navy to maintain the facility. When the decision to close the base in 1974 was finally made, about 400 still toiled on ship maintenance or keeping up yard facilities.

It took four years for the Boston Redevelopment Authority (BRA), a quasi-public entity, to acquire 105 acres in 1978. Since then, 19 buildings have been rehabilitated with the assistance of \$470 million in private investment, making this the largest preservation and reuse effort in the United States. In addition, three new construction developments added 302 housing units. In total, there is now:

Office	354,000 gross square feet
Medical research	701,000
Retail	37,000
Parking garage	703,000
Housing	1,237,000
Total	3,032,000 gross square feet

Massachusetts General Hospital occupies nearly all the medical research space, but a biomedical firm is also a tenant. The Massachusetts Water Resources Authority has much of the office space, and some BRA offices are located there. There are 614 rental housing units in rehabilitated structures, and 320 new construction condominium units. One hundred seventy-one of the 934 housing units are occupied by low- and moderate-income households — gross incomes at or below 50 percent or 80 percent, respectively, of the metropolitan area median income. Along the way this development provided 2,000 construction jobs, 2,800 permanent jobs, and annual property tax revenues of \$4 million; \$67 million in construction paychecks and an annual \$89 million in paychecks to permanent workers ripple through the regional economy, creating employment.

With the exception of the housing developments that include low- or moderate-income units, the redevelopment of the yard took place essentially under market conditions, that is, without public subsidies. Many of the rehabilitated structures were historic and the land under them remains in BRA ownership under eighty-year ground leases. Outside of the historic district the ownership has been transferred to the developers. Aside from the affordable housing components, public subsidy was confined to parking, utilities, street improvements, Harbor Park surface features, and landscaping.

For example, some surface park improvements, landscaping, and utilities were funded by:

U.S. Department of Housing and Urban Development (HUD)	\$ 761,000
Massachusetts Coastal Zone Management	560,439
Boston Capital Loan Order	795,256
Boston Redevelopment Authority	346,247
Total public funds for park improvements	\$2,462,942

Much of this public money will be repaid to the city and be reused for other affordable housing and community economic development activities.

The \$7 million conversion of Building 103 into elderly apartments was subsidized by a HUD Urban Development Action Grant (UDAG) for \$1.6 million. Through state tax-exempt bonds, the quasi-public Massachusetts Housing Finance Agency (MHFA) put in \$3.5 million in construction and permanent financing at 1.5 percent to 2 percent below market-rate interest (possible because of the tax-exempt bond status). The state Executive Office of Communities and Development (EOCD) is paying out an operating SHARP (State Housing Assistance for Rental Production) over a period of fifteen years. In return for SHARP assistance, 25 percent of the units will remain occupied by low-income tenants who will also receive state 707 rental assistance. All the other units were leased at rents affordable to moderate-income households.

Fifty new construction condominium units were developed for moderate-income homebuyers. MHFA provided below-market-rate financing to the condo buyers. The city of Boston provided an additional subsidy of about \$21,000 per unit for ten units, which enabled households with gross incomes at or below 80 percent of the metropolitan area median income to purchase them.

In addition to the \$470 million of private investment that financed nearly all the Navy Yard development, ground lease and other revenue to the Boston Redevelopment Authority will continue to provide a resource for further community economic development activity in Boston.

The growth climate in the Massachusetts economy during 1978 to 1986, when all the completed development deals were put together, aided the public sector managers of the base conversion in obtaining the necessary private investment. Space is still available for substantial additional development in the yard. The conversion includes 22 acres of open space (park, pedestrian mall, harbor walk), a sailing center and marina, two day-care centers, and retail shops.

Source: BRA's *Master Plan* for the Navy Yard; my experience as a fiscal manager for the city's UDAG grants and other federal funds; conversations with BRA program managers.

South Boston Naval Annex and South Boston Army Base

Long unused holdovers from the Cold War, these two facilities were closed in the mid-1970s and mid-1980s. Their conversion, as with the Charlestown Naval Shipyard, was a boon to the area, because facilities that were employing few and producing little became economic engines for the regional economy. The conversion of these two bases resulted in \$140 million in private investment by tenants for capital improvements to leased space, and the presence of 150 companies and 3,500 jobs.

In April 1973, the Department of Defense announced the closing or curtailment of forty military bases across the nation. Five were in Massachusetts, including the Charlestown Naval Shipyard and the South Boston Naval Annex. Reuse was facilitated in 1973 with the award of a key \$420,000 from the federal Economic Development Administration (EDA) to plan for the conversion of both bases. Within a month following the announcement of the closing plans, the state had established the Joint Commission on Federal Base Conversion, which recommended establishment of the Massachusetts Government Land Bank (MGLB).

The MGLB was to use state general obligation bonds to help acquire and convert closed base facilities and provide technical assistance to impacted communities and development entities. The MGLB was quickly established and given authority to do up to \$40 million in financing. In 1987 it acquired the South Boston Naval Annex for \$4.9 million and simultaneously transferred it to the Boston Economic Development and Industrial Corporation (EDIC). Subsequently, the federal General Services Admin-

istration (GSA) returned \$1.6 million. The MGLB acquisition was done on a forty-year permanent financing basis, so that EDIC is paying off the Land Bank mortgage over that period.

The EDIC is a private nonprofit industrial and commercial development and operating entity created by the city of Boston, with a city-appointed board (a quasi-public organization, similar in this regard to the Boston Redevelopment Authority). Formed in 1971, its major activity has been the conversion of the Naval Annex and the adjacent South Boston Army Base to the Boston Marine Industrial Park (BMIP). The Naval Annex (167 acres) and the Army Base (24 acres) together left EDIC with 191 acres and 32 buildings containing 3,028,000 square feet to convert to civilian use.

The Army Base was acquired much later, in 1985, with \$1.3 million of tax-exempt industrial development bond funds and a federal Department of Housing and Urban Development (HUD) \$2.2 million Section 108 loan. The financing for both bases was at below-market interest rates.

Funding sources for the Naval Annex redevelopment, in addition to the Land Bank, included the federal Economic Development Administration, the state Coastal Zone Management, city of Boston general obligation bonds, and private investment. By 1980 the Naval Annex portion had fourteen tenants employing 1,500 people.

Another quasi-public agency, the Massachusetts Port Authority, leases 47 acres — nearly a third of the Naval Annex portion — for shipping terminal and auto import storage purposes. It included two warehouses, a cement off-loading facility, and the Black Falcon cruise terminal, as well as EDIC's Boston Technical Center (BTC), which offers twenty- to thirty-week courses developed in collaboration with twenty-five employers.

BTC and its students receive funding from the U.S. Departments of Labor, Education, and Housing and Urban Development, the Massachusetts Departments of Education and Employment and Training, Bay State Skills Corporation, and private foundations. BTC graduated its first welding class in 1978. It had graduated 350 students by 1980, by 1989 it had 2,500 graduates, and its courses included medical secretary, machine tool setup and operation, and business machine service.

Of the two drydocks maintained, one is used for ship repairs and the other, a very large one, EDIC hopes will be used to manufacture or finish the steel tubes for the future third harbor tunnel.

The Army Base portion consisted mainly of a single massive 1.65 million-square-foot (38 acre) building that is longer than Boston's Prudential Tower is high. The building houses the Boston Design Center, a wholesale center for residential and commercial design and furnishing trades; the Bronstein Industrial Center, which leases light industrial space, and Drydock center for manufacturing and graphic arts. The Army Base was redeveloped with:

EDIC tax-exempt industrial development bonds purchased by State Street Bank of Boston	\$5,900,000
Federal Department of Housing and Urban Development (HUD) Urban Development Action Grant (UDAG) 3% interest loan	3,644,000
Boston Harbor Limited Partnership sale of investment shares	3,200,000
HUD Section 108 loan	2,200,000
HUD Community Development Block Grant funds	1,500,000
Massachusetts Public Works Grant	600,000
City of Boston General Obligation Bonds	330,000
City of Boston Neighborhood Development Fund grant	285,000
Department of Defense Office of Economic Adjustment grant	125,000
Total	\$17,784,000

Source: Department of Defense, Office of Economic Adjustment, *Civilian Reuse of Former Military Bases* (c. 1990); EDIC, "Boston Base Closing Meant Business," 1991; MGLB Annual Reports, 1978, 1980; my experience as fiscal manager for Boston's UDAG grants and other federal funds.

Appendix E

Jobs with Peace and Regional Science Research Institute Methodology

In its 1985 *Massachusetts and its Military Industry*, Massachusetts Jobs with Peace (JWP) estimated that there were 73,000 direct and 31,000 indirect military jobs in Massachusetts, a total of 107,000 jobs, or 3.75 percent of all those employed in the state.

The data do not exist to enable accurate computation of direct and indirect (suppliers to military businesses and bases) military employment. One reason is that there are hardly any data on subcontracting by firms receiving military R and D and production prime contract awards. Based on various assumptions, Jobs with Peace estimated that subcontracting out of and into the state equaled each other and produced a zero net employment effect.

JWP broke down prime contract awards into four-digit standard industrial classifications and fed the data into the University of Massachusetts at Amherst's Regional Science Research Institute's input-output model of the state's economy. No computations were necessary for direct uniformed and civilian employment at military bases, since these numbers are provided by the Pentagon. Various assumptions were used to pick multipliers for indirect jobs generated by bases and by private industry.

JWP estimated that the time lag between awarding of prime contract and expenditure of the funds in R and D and production averaged about one and a half years. Thus the 1985 employment estimate was based on 1983 prime contract awards. In constant 1982 dollars, Massachusetts prime contract awards were just under \$6 billion in 1983, peaked at just under \$8 billion in 1986, and dropped to just over \$6 billion in 1988. My estimates in the "Military Taxes and Jobs" section are based on factoring the computations from the earlier study, assuming that 1990 employment reflects 1988 prime contract awards.

In one reality check, JWP noted that Raytheon Corporation, the state's largest military contractor (31% of Massachusetts prime contract awards in 1983), announced in 1984 *Boston Globe* advertisements and articles that they employed 40,000 in Massachusetts, 19,000 of whom were doing full-time military work. Computed according to JWP's methodology, Raytheon's 1984 military employment was 18,000.

Data Resources, Inc. (DRI), the prestigious Lexington, Massachusetts, economic forecasting and analysis firm, is the regional source that the press and most studies rely on for estimates of military employment in New England. The Jobs with Peace study compared DRI's methodology with its own and noted that DRI estimated the military employment share of the Massachusetts work force about 2 percent higher than JPW did — just under 6 percent instead of just under 4 percent. However, DRI consistently overestimated in the 1980s by not allowing for a time lag between prime contract awards and the actual expenditure of funds in workplaces. Had DRI taken this into account, its estimates would have been about 1 percent instead of 2 percent higher than JWP's.

Notes

1. Rebecca Stevens, Peter Dreier, and Jeff Brown, *From a Military to a Housing Buildup: The Impact in Boston of a Six Percent Shift in the Federal Budget from the Military to Housing* (Boston: Boston Redevelopment Authority, 1989).

2. Thomas Bodenheimer, "Public or Private? The Way to Real Health Security," and Andrew Kopkind, "National Health Care: Seizing the Historic Moment," in *The Nation*, December 16, 1991. These companion articles do a fine job of condensing the confusion regarding the plethora of health care reform proposals drifting in the wind. Bodenheimer, a physician, explains that there are basically two options being proposed.

One option is a reform that leaves the present system intact and adds, in varying degrees, some public coverage for the poor who are now not covered, and adds coverage for currently uncovered employees by forcing their employers to cover them, or pay into a coverage pool. This option will not contain spiraling costs, but will increase them. So far, increasing costs has meant great hardship for workers and companies alike in paying insurance and nonreimbursed health expenses. Increasing costs has also meant reduced coverage. Forty percent of the poor are now covered, whereas 70 percent were formerly covered. More firms are refusing to cover employees or shifting more of the cost to the employee.

Under this system, as with the present system, at least 25 percent (\$175 billion) of 1991 national health care expenditures of \$700 billion went for administration — hundreds of insurance companies, hospitals, and doctors pushing paper back and forth at one another.

The second option, a health security system, would retain the current private health care system but replace private insurance with public insurance. As the Canadian and German systems demonstrate, this approach can stop the rapid rise in health care costs. Bodenheimer says that the first option would cost \$50 to \$80 billion more per year, but that the health security system would save \$67 billion per year (mostly in administration) for a net difference of \$117 to \$147 billion per year. This difference is roughly equal to the entire peace dividend projected for the coming years.

Regardless of the health care merits or demerits of the two approaches, there will probably be no shifted military funds available for anything other than health care unless the health security approach is adopted.

3. Michael Frisby, "Pressure Rises for a New U.S. Budget," *Boston Globe*, September 13, 1991, 3.

4. David Bond, "Kremlin Cabal's Failure Fuels Defense Budget Debate in U.S.," *Aviation Week & Space Technology*, August 26, 1991.

5. Ibid.

6. This is, in my opinion, the most accurate and sensible definition of federal military spending around, and is the definition used by Military Research Services, Inc. (MRS), among others. It includes the government's own definition, which is the "defense function": the budget of the Department of Defense (DOD); the nuclear weapons development and production budget of the Department of Energy (DOE); and the defense-related activities of several small programs, such as Selective Service, Federal Emergency Management Agency (FEMA), and the Ready Reserve Fleet (1989, \$298.3 billion).

In addition to defense function, the MRS definition I am using includes International Security Assistance (1989, \$2.8 billion); military activities of the National Aeronautics and Space Administration (1989, \$1.1 billion); and military-related interest on the federal debt (1989, \$51 billion — about half of all 1989 debt payments).

7. While quality-of-life comparisons are more difficult, employment comparisons resulting from federal spending alternatives are quantifiable. Some sources include publications of the federal Department of Commerce's Bureau of Labor Statistics; various books and articles by Seymore Melman and associates; various publications of Employment Research Associates; and the Jobs with Peace study *Massachusetts and Its Military Industry*.

8. *Massachusetts and Its Military Industry* (Boston: Massachusetts Jobs with Peace, 1986). See Appendix E of this article for a summary explanation of the Jobs with Peace employment computation methodology.
9. Diane Lewis, "Report: N.E. Lost 250,000 Jobs in '90," *Boston Globe*, February 28, 1991, 45. A July 1991 U.S. Bureau of Labor Statistics report stated that Massachusetts had lost 175,000 jobs in the year ending in mid-1991, and 313,000 in the past two years. That equals nearly one out of every ten jobs in the state (Charles Stein, "Massachusetts' Job Losses Continue to Break Records," *Boston Globe*, August 4, 1991, 93). In the recession of 1974–1975, the state lost 4.7 percent of its jobs; in 1981–1982, 1.9 percent; between June 1989 and June 1991, 9.9 percent. Between June 1990 and June 1991, Massachusetts lost 5.8 percent of its jobs, a higher rate of loss than any other state in the nation. During that year Maine lost 5.4 percent, New Hampshire 5.3 percent, Rhode Island 4.3 percent, Vermont 4.1 percent, and Connecticut 2.5 percent. The only state in the nation with a loss greater than any of the six New England states was New Jersey, with 2.7 percent (U.S. Bureau of Labor Statistics).
- Most professional studies and press articles in the past twenty years have overstated the military dependence of the New England economy on military spending. See Appendix C for my critique of a typical example, published at the end of 1991, Richard Barf's "The Pentagon and the Cities."
10. See Appendix D of this article for detailed accounts of the conversion of three Boston military bases to civilian use: the Charlestown Naval Shipyard and its South Boston Naval Annex, and the South Boston Army Base.
11. Boston Mayor Raymond Flynn thinks that the S and L bailout will cost \$500 billion (Nancy Walser, "Make the Rich Pay for S&L's, say Flynn, Rep. Kennedy, Others," *Boston Globe*, 1991). According to Congressman Kennedy, a member of the House Committee on Banking, Finance and Urban Affairs, data from the General Accounting Office and the Office of Management and Budget indicate that under the present bailout legislation, the total cost could be \$1.4 trillion, \$913 billion of which would be interest on borrowed funds. There is no question that the administration and Congress are handling the bailout in a manner designed to conceal the costs to the taxpayers. If, as Congressman Kennedy's proposed legislation would require, the bailout were primarily paid for out of current revenues over the next few years, the cost would be a minor fraction of what it will be under the present approach, which is primarily using borrowed funds and spreading the cost far into the future — at high interest rates. See Kennedy's "Who Should Pay for the S&L Bailout?" *New York Times*, September 21, 1990.
- Housing scholar Michael Stone of the University of Massachusetts at Boston estimates that at the \$500 billion figure, Boston residents will fork over \$3.2 billion (one third of the city's annual budget, \$5,600 per resident). The \$77 billion appropriated for the 1990 S and L bailout cost Boston taxpayers \$175 million (\$300 per resident).

Question

Edward Baros

What happens when the world
suddenly glows distant and life
slips away into darkness or
when the light of love and hope
has gone and happiness becomes
a figment of imagination?

When you reach out to touch
and there is nothing to touch,
or to talk and there is
no one to answer you except silence?

What happens when you want to
put the right pieces in your
puzzle of life together and you
find that the important piece
is missing?

What happens when you have
issued out yourself in
tiny segments and didn't
reserve any for yourself?

2/4/91

The Last Thing We Need Is Another Shelter

Jessica Segré

Segré suggests that family homelessness is merely the latest and most devastating example of America's lack of commitment to children and families. The history of human services for children is presented to show that, both at the community and at the policy levels, this population and its needs have been neglected, subjected to fragmentation, and consistently downgraded on our lists of priorities. The societal values that have led to this situation are discussed and revealed as still reflecting an individualistic, frontier outlook, which is, however, becoming an anachronism. The need for a child/family policy is stressed, as is the urgency of reexamining and modifying some of our basic tenets in order to prevent the recurrence of such inhumane outcomes as homelessness.

Our methods of care and our thinking are intimately interwoven into the fabric of society. If we look at just the warp and the woof, we will miss the design.

— Murray Levine

History and Politics of Community Mental Health

We usually think of “homeless children and families” as simply one of the groups that make up “homeless persons.” Numerous articles and reports have referred to the “different populations of the homeless,” dividing the category by age, by sex, and by family status. Also, in looking at the recent upsurge of homelessness, we can see an apparent sequence of vulnerability for different demographic groups: first single adults were most prominent, later kids and families came to the fore, still later, in some areas, the youth population is showing the largest increase in growth. Presenting information in this manner seems to imply that each group comprises a segment of an organic “homeless” whole. It suggests that the operative term in the phrase “homeless (adults) (youth) (families)” is the condition itself. It has also led to a search for the factors associated with homelessness, be they prior or succeeding, and to an emphasis on looking for similarities among affected populations as a means of identifying shared risk factors to homelessness.¹

Jessica Segré, a clinical psychologist, consultant, agency director, and researcher, who is active in community advocacy organizations, works in human services with low-income children and families.

When we make such comparisons, we've observed that, at the most basic level, all who are homeless lack a permanent roof over their heads. By the same token, we've noted that all of us share the need for this kind of safety and security, and that a "home" implies support as well as shelter. From these and similar observations, we have constructed our public response, an effort that has taken two major directions: (1) in the short-run, to provide the needed roof on a temporary basis, since being without shelter constitutes an "emergency" (more on this later); and (2) in the longer-term, to attempt to deal with the factors perceived to be associated with the problem: the lack of low-income housing; the mismatch between available jobs and job skills; our grossly inadequate entitlement structure.

It would seem as if, while human service providers, politicians, and bureaucrats have differed in their ideas about program priorities, funding levels, and time lines, they have generally agreed on the preceding approach to dealing with homelessness. And, in the language of the day, it is this approach which has served to micromanage the issues. By focusing on the details of shelter services, transportation routes, and employment programs — all necessary — we have at the same time diverted attention from some of the more fundamental issues: What are the overarching societal factors that have allowed homelessness to occur in the first place? Why are there *any* people who are without a place to live in late twentieth-century America?

To begin to find crucially needed answers to these questions, since our goal should be not merely to get through this crisis, but to ensure that it can never happen again, it may be helpful to reformulate our concept of the problem. One way to do this, which is easy in execution yet large in import, is merely by switching our emphasis. In looking at "homeless children and families," rather than focusing on homelessness, instead pay attention to what it's like to be a child or a family in our society, then look at homelessness as it relates to these circumstances. An advantage to this approach is that it puts the people part of the equation first and forces us to confront, from the outset, our values and attitudes toward others. (By contrast, when we start with homelessness, we have to travel a long, inductive route before finally dealing with a whole person).

It's important to state that in changing emphasis, I am not suggesting that looking at the attributes of homelessness *per se* is invalid. I am, however, saying that such a focus is by nature incomplete and has perforce led to solutions that are also short of the mark. This is so because such "solutions," by and large, have dealt with homelessness as if its causes were not embedded in our deep-rooted cultural values, and as if addressing outward manifestations of the issue would somehow, magically, cause inner, endemic problems to heal.

The remainder of this article will attempt to show that the presence among us of large numbers of children and families lacking the safety and support of a home is merely another example, albeit an extreme one, of a long-standing lack of commitment to the needs of these populations in this country. To illustrate our ephemeral concern for the young and their caretakers, I examine the sorry ways in which children have fared within the human service system, the very system set up to ensure their safety and support. I also discuss the specific values and attitudes that appear to be most antagonistic to fostering the development of children and families and show, as suggested, that they constitute some of our most dearly held principles.

I'd like to begin by presenting the story of a family, disguised in detail, but real in substance. I first met the R.'s when I was the director of a large, urban child and adolescent mental health unit in the late 1970s.²

Rachel R.

Rachel R. was a tiny, waiflike six-year-old with big brown eyes. When Gwen, her future counselor, first saw her, Rachel was crouched in a school closet, looking terrified, meowing like a cat. Ms. K., her teacher, said that this kind of behavior had been going on for some time, but had recently gotten worse. Ms. K. connected the child's increasing withdrawal and tendency to use odd verbalizations (she also barked) to the recent appearance of welts on Rachel's back and legs, and the teacher was quite distressed when her call to Protective Services was followed only by a perfunctory contact with Rachel's parents and a quick closing of the case. Ms. K. was particularly concerned, she told Gwen, because the R.'s were living out of a car parked in a supermarket parking lot, and she didn't see how that situation could not be detrimental to the child's well-being.

It took Gwen many weeks of trying before Rachel would speak to her. During this time, the child's behavior deteriorated further, and she began to have what her teacher termed "fits" of frantic crying, seemingly unable to control herself. Both Gwen and Ms. K. noted new bruises on Rachel, and both contacted the Protective Services Unit with the same negative results as before.

Gwen's attempts to talk with Rachel's parents resulted in one meeting with the whole family. At that time she learned that Mr. and Mrs. R. and their two children had only recently arrived in Boston from the rural South, and that neither had finished high school or had any particular skills training. Not surprisingly, both parents were unemployed. The family was living on welfare, and anxious that DPW not learn about Father's presence on the scene. Gwen was alarmed to see that Mrs. R. was pregnant, and that everyone looked malnourished and disheveled. Most disturbing, however, was the way Mr. R. treated his wife and children, who were not allowed to speak without his permission. He also displayed no apparent compunctions about slapping the little ones in front of the counselor. Gwen's offers of counseling for the parents, or for the whole family, were rejected.

The situation came to a head when Mr. R., angry at being reported to Protective Services, withdrew Rachel from counseling and kept her home from school. At that point, with no one left to monitor the situation, a joint agency meeting was called and pressure was exerted on Protective Services to undertake a more complete investigation of the case. They demurred, but said that they would provide parenting and other services if the R.'s asked for them voluntarily. The caseworker, who was new both to her job and to the field, said she believed Mother's assertion that Rachel's bruises were accidentally caused and suggested that the child's behavior was a "stage" she was going through.

Meanwhile, fearing that Rachel's fragile functioning would finally break down altogether, Gwen had been trying to arrange an inpatient psychiatric evaluation for the child. Such a procedure would have allowed Rachel to be observed away from the family and aided in explaining her behavior. While Gwen had her doubts about getting the parents' consent for this arrangement, it turned out that she needn't have spent time worrying. With Medicaid as the only source of payment, there were so few child beds in Massachusetts that it would have meant a year's wait. A second option considered, a straight inpatient admission, was also abandoned when the only public child psychiatric hospital in Massachusetts refused even to evaluate Rachel for a possible slot.

There is no neat end to this story. After two years and the intervention of the court owing to the youngster's long-term truancy, Protective Services recommended a residential treatment facility for the child, and asked Gwen to become reinvolved as her counselor (the child had repeatedly requested this). By this time, both Rachel's younger siblings had also been reported for possible abuse. Rachel began to come out of her shell in the treatment facility, but quickly regressed when she returned home — precipitously, due to the agency's unexpected closing. The clinic was able to continue to follow this family after a fashion for many years, through successive requests for information from ever-new agencies and systems. The last we heard about Rachel, she had just been admitted to an adolescent psychiatric hospital after having tried, nearly successfully, to kill herself.

The Service System

Much has been written about the relationship between the mental health system and single adult homelessness, usually in terms of the proportion of the latter population with psychiatric illness, frequently to talk about a less-than-successful deinstitutionalization policy.³ However, there has been almost no comment on the equally strong, though somewhat more complex, connection between our mental health policies and family homelessness. There are several reasons why this might be so. In the first place, single adults constitute the most obvious of the homeless populations; they wander the streets, sleep in doorways, and otherwise intrude on our senses. Their peculiarities are frequently displayed publicly; we can almost not avoid seeing them. Homeless families, by contrast, may be quite effectively hidden from the rest of us unless we know where to look: in shelters, on food lines, inside overcrowded apartments.⁴ Homeless youth may be even less apparent than families, since they are frequently not simply "hidden," but actually hiding from others, like the police.⁵

Another reason that we may not have understood the relationship between family homelessness and the mental health system appears rooted in our unquestioning acceptance of that system's current view of its mission: to treat the chronically and seriously mentally ill population. Since studies have shown that relatively few homeless families have members with severe mental illness,⁶ we seem to have gone no further in pursuing a possible connection. This is so despite the fact that we talk quite freely about the stresses and strains of being without a home, for both children and parents, and the lack of support services available to address these issues. There is something ironic in having a mental health system which deals only with the most seriously ill. It would appear more accurate to say that what we actually have is a mental illness system, and that there is no public entity with responsibility for mental health.

A third reason for the lack of association between "mental health" and family homelessness stems from a laudable desire to avoid stigmatizing the population — a position again based on the system's narrow definition of its purview. Not only do mental health departments deal almost exclusively with chronically mentally ill clients, but they also perceive their clients' problems (read: illnesses) to be primarily biological in nature.⁷ This formulation inevitably results in treatment according to a medical model: evaluation; diagnosis; reliance on chemical remedies; and supervision by a physician (psychiatrist). There is no question as to who is the doctor and who the patient. Given this model, we would assume that a family involved with the

mental health system is "sick" and dependent, with all that these designations imply. It would be hard to fault those wishing to avoid such labels.

But the medical model, essentially a straightforward illness-and-cure-by-a-doctor approach, is only one among many ways that people try to help others. Because of its simplistic view of problems, its quick resort to drugs, and its insistence on diagnosable illness as an admission ticket, it has never been a model in much favor among people working with children.⁸ As is clear from Rachel's story, "children's" problems are far from simple, and diagnostic labels, at best, don't do justice to the complexity of developing organisms.

However, the most important reason that we have not delved further into the connection between mental health and homeless families seems to be that we've been considering the relationship between these two factors from a direct cause-and-effect perspective: either mental health problems lead to homelessness or the other way around. Having found neither proposition to be true to any great degree, and feeling that the very formulation is counter to our helping goals, we have abandoned it. But the real association between family homelessness and the mental health system is that each has evolved to its current state because of the same societal factors and processes, and that each is inimical to children and families. A crucial connection indeed.

At this point, to gain a better understanding of just what happens to children and families within the human service system, let's turn to a discussion of Rachel and then to a brief historical review.

Rachel R.: Family Issues and Response

Only three factors distinguish the R. family from the typical clients seen on the Child and Adolescent Unit in the late 1970s: (1) the family was "intact," meaning that Father was present; (2) Rachel's behavior was more disturbed at a younger age than the average; and (3) the family was literally "homeless." In all other respects, the R.'s were quite like our usual clients, that is, they were on welfare, violence was a part of family life, attempts to help involved the efforts of multiple systems, resources were limited and waning, and trying to provide some appropriate and useful service was problematic and frustrating. That the R.'s were typical belies the image that child clinics see mainly middle-class families and deal with "little" problems from a traditional psychoanalytic perspective. This is a point of view still heard,⁹ apparently a remnant from the heyday of the child guidance centers, which have also long since changed their clientele and perspective.

As suggested above, the issues presented by the R.'s were complex, and "complexity" is almost synonymous with "children's services." In the first place, the term itself is a misnomer since "Children's services are not services exclusively for children, but services to the family unit."¹⁰ Thus the interests and rights of *each* family member must be considered, although, as with the R.'s, members' interests often conflict with one another. Then, trying to protect vulnerable children can be tricky, since parents may simply stop bringing them. At the same time, having a youngster in counseling engenders some guilt in most of us as parents, so that absent danger it becomes important to counteract these feelings and reinforce parent-child alliances. It's always important to support parents' skills, and thereby to strengthen and empower them. However, the two parents' interests may also not coincide. How then to help each? To protect each? To garner for each needed services?

In addition to the family, children are also embedded within a number of other systems, such as school, welfare, protective services, and so on. Helping always involves relating to each of these systems and essentially re-creating the child's environment within the helping framework. Each agency and system has its own mandates, its own professional requirements, and its own territory; disagreements may result as much from inadvertent misunderstandings as from real differences in points of view. In the R. case, differing missions, qualifications, and turf were all involved in our poorly coordinated handling of the case. For example, the Protective Service worker later told us that she had dug in her heels about the abuse because she thought that we were trying to tell her how to do her job. The more frantic we became, the more other agencies concurred, the more she backed off. But other agencies had no mandate to pursue the violence. And time is a more precious commodity for children than for adults.

Finally, in looking at Rachel's story we can see how important it is to understand the process of development itself, without which we can't really assess what's going on. Is the behavior "just a stage" or a reasonably appropriate reaction to abuse or chronic stress? What if Rachel had been four instead of six? And so on.

I've gone into some detail about a few of the issues presented by the R.'s to illustrate two points. First, child mental health practice, as it occurs in community clinics today, is a broad-spectrum affair which, as noted, undertakes to work directly or indirectly with all the players and the agencies in the child's/family's life. As implied, the conceptualization of treatment is systemic and ecological, and internal causation, be it intrapsychic or biological, is simply one of a long list of possible explanations for behavior. Thus, it would appear as if both the form and the substance of child/family work differ from the medical model, predominant in the mental health system today, and there seems no question but that the differences would be greater were child professionals not constrained to work within that system.

Second, and clearly following from the preceding, the skills needed to help children and families are equally far ranging, and they are also *particular* skills. Being trained to see adults, and to conceptualize the needs of this population, does not qualify one either to work with children directly, or to speak about their conditions and requirements with authority. We will see later how crucial the latter issue has become.

Rachel R.: Service System Issues and Response

The saddest commentary on Rachel's story from a service perspective is that, in retrospect (only), it looks as if it took place in a time of relative plenty — before the cuts in human services implemented by the Reagan administration;¹¹ before the further cuts in children's programs in Massachusetts;¹² long before the current recession. Yet gaps and distortions in service are very much in evidence in this example. For one thing, the R.'s had no home, and living out of a car surely exacerbated everyone's level of stress and Father's tendency to violence. Mother was reluctant to pursue public housing or to get involved with any government agency more than she absolutely had to, because she feared that Father would be "discovered," and they would be disqualified from AFDC. While no longer the case in Massachusetts, there are still many states that deny AFDC to two-parent families — a good example of the antifamily bias contained in many of our official policies.¹³

Although worse was to come, we can see gaping holes in the continuum of mental health services. The one public mental health hospital for children mentioned remains the only such unit in the state, and as of this writing public hearings are under way to

determine if it, too, should close.¹⁴ Although hospitals, treatment centers, and other types of out-of-home placements are far down the line in terms of options for children, they need to be available and to be equitably distributed. As Rachel's story suggests, both these issues are relevant, and it is interesting to note that, while child and adolescent admissions to public psychiatric hospitals have decreased markedly in recent years, those to private hospitals have more than correspondingly increased, suggesting that the issue is not the treatment modality per se, but who is entitled to it.¹⁵

The need for accessible prevention, early intervention, and prompt health and social services are all highlighted by this story. In fact, the child unit would probably never have seen Rachel had it not had an outreach component in her school. But where were the pregnancy-related services? Job training? Appropriate educational opportunities? Why did it take violence to get society's attention at all? What future can we really expect for any member of this family? The thought is depressing.

However, at the time, the response of local service providers to the many Rachels we saw was actually quite optimistic. We organized. We formed an areawide Children's Committee consisting of all child/family serving agencies, and determined that we would identify and do something about the problems that we and the clients were experiencing.¹⁶ Clearly we felt that this was possible. Had we been more aware of the history of such efforts (below), I'm not sure we could have summoned the energy.

The aim of our committee was to establish a coherent, coordinated system of services to address as wide a spectrum as possible of child/family issues (recreation, day care, early intervention, protective services, education, health, mental health, substance abuse, legal problems, emergency services, and so on). We foresaw a single community entry point for a number of the services, a twenty-four-hour information and referral program, and an ombudsman or family advocate to facilitate clients' smooth passage through programs. To begin, we undertook a joint professional-community needs assessment process, and in line with this participatory ethic, we felt it important to redefine the concept of "treatment." We proposed abandoning the term itself (although we never did agree on a substitute), while at the same time vastly broadening the types of activities included under this rubric. We saw the process of helping as a collaborative, problem-solving endeavor, rather than a hierarchical, agency-driven imperative (this was pre-empowerment).¹⁷

Of all issues, that of effective interagency collaboration struck us as most crucial, since demands for service were increasing while money for programs was not. Collaboration was something that we could do, with no additional funding, which could at least plug some holes in the system and prevent the kind of interturf warfare that hampered the R. case. So we spent a lot of time getting to know one another and the mandates and missions of our various agencies. We also identified troubleshooters to mediate within our own group. We even began to develop joint protocols for service and referrals, and to wrestle with the thorny issue of client confidentiality within an affiliated network.

Finally, we approached our parent departments for money to staff our efforts. We pointed to time analyses showing savings in such areas as processing clients, negotiating with other agencies, and providing information and referral. We emphasized the preventive side to our endeavors: with good relationships and a shared knowledge of community resources, clients were receiving a package of services, and problems were being dealt with before they became intractable and enormously costly. At the other end of the service spectrum, we were also saving money, since we were

resolving difficult cases among ourselves, so that few had to go on for interdepartmental mediation. Further, as a group, we'd been successful in writing service proposals; it was staffing we needed.

We thought that we were on to something. We had actually begun to implement a planned, rational system of services in a low-income, multineed community. We felt that this accomplishment was particularly important since by that time (early to mid-1980s) we were beginning to see more and more children and families with multiple and serious needs, at ever younger ages. We made the latter point repeatedly. Without services and support, without appropriate opportunity, these children would not learn how to function independently, could not grow into responsible adults. We were setting up a time bomb.

As you've probably guessed, we did not succeed in shaking loose money for the organization from any state agency, nor did any department adopt the concept and run with it. I was baffled by the response of the Department of Mental Health, which evidenced no interest whatsoever in helping us and basically ignored our efforts. While I had no illusions that the department had any interest in children, I was surprised that it didn't pick up on a program which was helping to relieve it of unwanted responsibility. The Department of Social Services, which was more supportive and sympathetic, did entertain a proposal from us, but in the end said that they wanted to fund "new" efforts, and that ours, then five years old, was already "established" in the community.¹⁸ Established, yes, viable, no, since those of us involved could no longer put in the countless hours of unpaid time required to make it work. With much regret and some disbelief, we disbanded.

History

In the year 1991, the status of children in this country appears as dismal. One recent author, after reciting a litany of deficits in such areas as low-income housing, jobs, welfare, prenatal care, and educational opportunity, concludes that "child neglect has become endemic to our society."¹⁹ A report tells us that "our nation's children are at greater risk today than at the beginning of the 1980s,"²⁰ and goes on to inform us that 20 percent of all American children, and an astounding 43.8 percent of all black American children are now living in poverty. Yet these figures differ little from those of twenty years ago when "One-fourth of American children under age 18 live[d] in poor families. Nonwhite children [were] almost four times as likely to be disadvantaged as white children."²¹

If the status of children is depressing, the state of the service systems ostensibly designed to help them defies characterization. Quotes from local and national sources over the last two decades give the general picture:

In spite of our best intentions, our programs are insufficient; they are piecemeal, are fragmented, and do not serve all those in need. Unwittingly, we have failed to commit our vast resources to promote the healthy development of our young.²²

The Special Commission also uncovered an absence of coordination of the many different agencies providing children's services. This has resulted in agencies refusing to care for other agencies' children, identical services being offered by several agencies, and lack of consistent case management, case referral and cost-sharing policies.²³

Further, it is sad to note that, among child-serving agencies, the Department of Mental Health, the agency one would assume to be the monitor of child (and adult) well-being, has been a particularly frequent object of criticism at both state and national levels. For example:

The story of the (Mass) Department of Mental Health is one of ineptitude, misfeasance and misguided priorities. This state agency, responsible for the mental health of our citizenry, largely disclaims responsibility for children.²⁴

Like states, the federal government has paid little attention to disturbed children and adolescents. The lack of adequate targeted funding, organizational visibility . . . standards, training, or cross-agency efforts apparent at the state level is repeated at the national level.²⁵

The Early Period

To best illustrate the continuity in our thinking and responses, I'm going to begin this history with our own beginnings as a nation, in the early nineteenth century. At that time, the debate over the merits of public versus private, and institutionally based (indoor) versus individually based (outdoor) relief was already much in evidence. By and large, the history of the nineteenth century is the story of the rise of institutions and the increasing assumption of public responsibility for social problems, at least at community and state levels. However, even during this early period, there were differences in the way we structured our responses to perceived child and adult issues. These disparities, as we shall see, were to set the stage for future difficulties in creating comprehensive service systems.²⁶

In terms of public institutions, the primary kinds of facilities developed to address the needs of the poor, including the indigent mentally ill, were state psychiatric hospitals for adults (usually males), orphan asylums and reform schools for children, and almshouses for the poor. Since the concept of child mental health did not yet exist, there were obviously no institutions to deal this problem; therefore our incipient public mental health system was one focused on adults. And, as mental health historians have chronicled in detail, the system components, state hospitals, proliferated in number and expanded in size throughout the 1800s. By the end of the century, the hospitals had evolved from relatively small institutions practicing humane therapy to "cure" their charges into huge holding operations for patients felt to be chronically ill and virtually "incurable." And the administrators of these facilities, male psychiatrists educated in elitist universities, had even by then succeeded in institutionalizing their own role as experts in the treatment of psychiatric patients. The psychiatrists were able to accomplish this feat, despite not curing their patients, owing both to their monopoly of high-level positions in the field and to the growth of their own professional organizations.²⁷

Public institutions for children, as noted, were first established to deal with two groups of youngsters: those who had been orphaned or abandoned (orphan asylums) and those who were either already delinquent or thought to be in danger of becoming so (reform schools). In addition to publicly funded programs, private philanthropy provided a major source of support for children's services and was to continue in this role long after analogous efforts for adults were supported primarily by public funds (see Child Guidance Movement, below).²⁸

Social services for children and welfare services in general were predicated on an Anglo-Saxon (Puritan) philosophy that equated poverty with laziness and other personal vices. Hard work and inuring privation were seen both as preventive measures against poverty and as antidotes to the condition itself. Care was taken in social programs neither to give too much, lest the recipient lose the incentive to work, nor to give to those not seen as "deserving," or capable of working themselves. The righteous horror of poverty was such that youngsters living with their families in almshouses were actually removed to orphan asylums so that they would not be corrupted by their surroundings (including their indigent parents), and could be trained according to proper moral principles.²⁹

With the turn of the century came new efforts at reform. In the mental health arena, the mental hygiene movement emerged and made a valiant attempt to modify the state hospital system, in part by advocating the addition of outpatient services. However, as late as 1935, a national survey found that only half the state hospitals had developed even token outpatient departments. According to David Rothman, the institutions and their administrators had become a self-reinforcing system, with the psychiatrists loath to agree to any changes they saw as reducing their growing influence and power.³⁰

Children's reform efforts shifted focus at this time from the individual child to the child-within-a-family-and-community. New coalitions of advocates and professionals were formed to deal with such issues as child labor, slum conditions, and maternal and child health. Two landmark accomplishments of the new groups were the establishment of the Federal Children's Bureau in 1912 and the passage of the Sheppard-Towner Maternal-Infancy Act in 1921. The latter, which provided grants to states to establish departments of maternal and child health, was soon allowed to expire, such was the opposition from state governments and the American Medical Association (AMA) to this "imported socialistic scheme." The Children's Bureau, however, set up with the broad mandate to "investigate and report . . . upon all matters pertaining to the welfare of children and child life,"³¹ survived in one form or another in the federal bureaucracy until the 1960s. Undoubtedly, the height of its influence was in the early years, when its comprehensive plan to address child health and welfare issues became the basis for Title V of the Social Security Act. Enacted in 1935, this legislation served finally to validate the role of the federal government in child welfare, by establishing the Aid to Dependent Children program, which also institutionalized the concept of the deserving poor at the federal level.

The Child Guidance Movement

The Child Guidance Movement, probably the single most innovative effort ever in the "child mental health" field, and the effort that launched the term itself, began in the second decade of this century. The movement was an outgrowth of reforms in the juvenile justice arena, and it built upon the interdisciplinary team method developed in the new juvenile court clinics. Its ambitious agenda was summed up in 1934: "Historically, [the Child Guidance Clinic] owes its existence to the broader concern . . . with the age-old and overwhelming problems of delinquency, mental disease and dependency."³²

Conceived and supported by the Commonwealth Fund, child guidance was initially a preventive effort in which child-and-family outpatient clinics collaborated with schools, health, and social service agencies to "study" and treat children's prob-

lems before they led to more serious acting-out behavior. Eight demonstration clinics were set up in as many U.S. cities, and money was allocated for staff, training, research, and a cadre of affiliated school social workers. The emphasis on delinquency prevention was short-lived, however, and the clinics quickly began to deal with middle-class, garden-variety problem children. In 1927 the fund revised its priorities in favor of training and set up an independent professional institute for this purpose. In so doing, it extended its influence well beyond support of the program, which ended in 1945. It is therefore significant that a retrospective study of the training effort showed two important features: a psychoanalytic theoretical orientation, which also viewed psychiatrists as "in charge," and a pattern of discrimination against women and Jewish candidates (who were statistically more interested in this field) in favor of "elitist males."³³

Thus, by the eve of World War II, several critical characteristics of the human service system are discernible: (1) in terms of mental health, virtually all efforts, both public and private, child and adult, were controlled and run by male psychiatrists; (2) adult mental health services, publicly funded and hospital based, focused on individual clients; (3) children's mental health services, privately funded and outpatient based, targeted children and their family/community contexts (as child services had become increasingly dominated by male psychiatrists, they, too, had become more individually focused); (4) children's health and welfare programs, under the Children's Bureau and Title V, also systemically conceived, overlapped in purview with the guidance clinics; and (5) our welfare services continued to view giving in moralistic terms.

World War II and Beyond

The war itself had two important consequences for our chronicle, the first enduring, the second not. The enduring outcome (to date) was a change in the perception of mental illness as incurable, partly as a result of successful emergency treatment practices on the battlefield. The "discovery" that psychiatric conditions might be cured led in rapid succession to the passing of the National Mental Health Act of 1946 and to the establishment of the National Institute of Mental Health (NIMH) in 1949.³⁴

The pertinent temporary outcome of the war effort was the Emergency Maternity and Infant Care program, the most comprehensive federal effort in this sphere ever undertaken. The government, asking for no state matching money and no means tests for participants (as required by Title V), launched a program of total maternal and infant care services for soldiers' wives. This program lasted "for the duration" and was withdrawn immediately after hostilities ceased, when the prescription for women changed abruptly from "helping our boys" to "getting back to normal" at home.³⁵

However, the emphasis on helping those who had fought the war remained. In fact, it is Murray Levine's contention that

in the immediate postwar period, the Veterans Administration mission to care for the returning veteran dominated mental health efforts. Because so much was concentrated on the[se] . . . young and middle-aged males, the development of programs for . . . other populations [women, children, the aged] was neglected. Th[is] emphasis . . . led to a whole generation of mental health workers without training or encouragement to service other populations. It was the war . . . that defined the mental health problem, and . . . the solutions the federal government [would] support.³⁶

While Levine's thesis fits with the events that were to follow (below), the focus on the veteran was really only an extension of the system's historical concern with adult men. It's probably truer then to say that the war had merely provided a stronger rationale for continuing with the same emphasis.

And continue it did. NIMH allocated money for training, as noted above, and for research, and the 1963 Community Mental Health Centers (CMHC) Act provided funds to build facilities. The research yielded new groups of psychoactive drugs, hailed as miraculous, which ameliorated symptoms sufficiently to allow for early discharge from hospitals. Since the hospitals themselves had recently been scrutinized and found wanting, there was renewed call for reform: clean up the facilities; provide services in the community.³⁷

In 1955 Congress authorized a "nationwide analysis . . . of the human and economic problems of mental illness."³⁸ The study, conducted by the Joint Commission on Mental Health and Illness, was directed by Jack Ewalt, past commissioner of mental health in Massachusetts. "Action for Mental Health," published in 1961, summarized the group's recommendations. It called for greatly expanded outpatient and community consultation programs, standards of care, and continued research and training, all to revolve around chronically and seriously mentally ill adults. Not a word about children and families.³⁹

Actually, progress on social issues seems to have regressed during this period, as women had returned to the home, literally and figuratively. The decennial White House Conference on Children, initiated in 1910, had continued to meet and issue reports. However, "No one listened, and . . . the White House Conferences seem to have functioned as encounter groups and little else."⁴⁰ One thing that did occur was a postwar baby boom. There were soon more children flooding schools, hospitals, welfare agencies, and society. There was also considerable structural economic change after the war as industry moved to low tax areas and farms decreased in numbers and increased in size. And, a portent of things to come as the "boys" came home and families grew, was the enormous pressure on the housing market.⁴¹ The resulting U.S. Housing Act of 1949 established the goal of "a decent home . . . for every American family"⁴² and launched a number of federal efforts in pursuit of that goal. The language of the legislation seemed to imply that housing was a right for all Americans.

Then came the 1960s. First President John F. Kennedy and then President Lyndon B. Johnson led us to believe that something could actually be done about poverty and discrimination and inequity — and that they would lead the way. Suddenly people "saw" the problems that had been there all along; a spate of federal legislation ensued. We owe to the 1960s Medicaid, Medicare, comprehensive neighborhood health centers, and Head Start. A less fortunate legacy of this decade was the breakup of the Children's Bureau, transferred and demoted due to the reorganization of the Department of Health, Education, and Welfare (HEW) in 1967. The move was symbolic of two trends: increasing fragmentation and categorization of services and reliance on a "vertical" approach to service delivery, that is, having programs target all age groups under the same aegis.⁴³

Nowhere was this inclusive thrust more evident than in the CMHC Act and its subsequent amendments. President Kennedy, going beyond the recommendations of the Joint Commission, called for a "bold new approach," with an emphasis on prevention, community care, and service continuity. He specifically linked mental health problems to poor social, educational, and welfare conditions, and called for a gradual

depopulation of state hospitals.⁴⁴ As a requirement of the act, each state had to develop its own implementation plan. Reading through the Massachusetts plan, one is struck with the excitement engendered by the opportunity to reorganize a state system. Certainly the conceptualization was global.

Mental health is an issue with which every institution in our society is involved; the family, the school, the church, the employer, organized labor, the hospital, the settlement house, the police, the drug store, even the poolroom and the bar . . . The community mental health program must relate to and direct its efforts toward other significant institutions . . . The various services must be linked in such a manner as to assure continuity of care.⁴⁵

One area in which opinion did differ here was how best to include the required citizen participation in mental health activities. The plan records two points of view: (1) programs should be decentralized, with local communities maintaining control; and (2) programs should be left in the hands of professionals as "citizens would only get in the way." The compromise position left services largely in the hands of the Department of Mental Health (DMH), with a plethora of lay boards and committees to "advise" various administrative levels.⁴⁶

In all, the federal CMHC Act was amended fifteen times — in 1970 to include services for children.⁴⁷ Because the Joint Commission, and the CMHC Act itself, had so conspicuously omitted children and families, leaders in the child welfare and mental health fields had convened a commission of their own, the Joint Commission on the Mental Health of Children. Their 1969 report, "Crisis in Child Mental Health: Challenge for the 1970s," was the first of what was to become a long series of local and national publications outlining the disastrous state of children's services. It was also influential in adding children to the CMHC priority list.⁴⁸

Conceptualizing mental health in the broadest possible terms, "Crisis in Child Mental Health" talked about the effects of poverty, racism, social change, and a spotty educational system, and provided evidence to show that mental health services for children were actually less available in 1967 than they had been in 1930. The tone of the report was outrage. The solutions offered were a multitiered child advocacy system; a comprehensive community service program emphasizing prevention; and a whole series of programs to ameliorate poverty and social conditions, including a long section on housing. The latter stressed the need to undertake a massive program of construction and repair and cautioned that urban renewal efforts should not disturb families and communities. Noting the federal emphasis on adult services, the report expressed concern that "many child guidance clinics are currently the nuclei for mental health programs . . . their activities in behalf of children steadily declining. Supposedly, this diversion is temporary, but . . . it may not be unlikely that less services for children will be available within so-called comprehensive programs than was provided for children previously."⁴⁹ A prescient comment.

The Last Twenty Years: United States

We are now back to where we started this history. And, as the quotes at the head of this section suggest, the last two decades have seen steadily decreasing opportunity, steadily worsening conditions for children and families. These years have also produced considerable comment on this situation.

The marker event of the recent past was the election of Ronald Reagan. Unabashedly committed to giving to the haves, he immediately set about disman-

tling housing and human service programs, thereby increasing both the numbers and the plight of those who had fewer resources to begin with. Reagan also vetoed the 1980 Mental Health Systems Act. This product of the Jimmy Carter administration had called for a recommitment to the community aspect of community mental health, including increased collaboration between health, housing, and human service systems.⁵⁰ For children, the act had incorporated one of the recommendations of Carter's 1978 Presidential Commission on Mental Health, by authorizing funds to improve services to severely disturbed youngsters.⁵¹

The president's commission itself had actually outlined a much broader set of needs. Noting that few of the recommendations of the 1969 Commission on Children had been implemented, it had designated youngsters as one of several "underserved" populations entitled to priority services.⁵² At about the same time, the Select Panel for the Promotion of Child Health, created by Congress to assess the status of maternal and child health, issued its own report, listing the following "major concerns": (1) known interventions were not reaching consumers; (2) there were wide gaps in health status by income and ethnicity; (3) emotional health needs were not being addressed; (4) health systems were unsupportive of families; and (5) programs were split, fragmented, and competitive with each other.⁵³

However, the most damning national report on children's services was Jane Knitzer's "Unclaimed Children," published in 1982. Utilizing data from all fifty state mental health departments and from the federal system, she concluded that "of the three million seriously disturbed children in this country, two-thirds are not getting the services they need . . . Only seven state departments of mental health have taken the first limited steps to create a range of . . . services for troubled children."⁵⁴ Her report was replete with depressing facts: both federal and state funds targeted medically restrictive care to the detriment of community programs; only 17 percent of federal CMHC dollars were spent on children, although they comprised 32 percent of the population; few state mental health departments contained children's units; other children's agencies, such as welfare and protective services, had virtually ignored mental health issues; coordinated service systems were few and far between. Unlike previous exposés, Knitzer's did produce changes. NIMH responded by allocating money for the Child and Adolescent Service System, an effort to establish comprehensive systems of services for seriously disturbed adolescents. While an important undertaking, the program was limited in scope and addressed itself only to those with the severest problems.⁵⁵

Massachusetts: The Recent Past

What about Massachusetts? How well had we succeeded in implementing the far-reaching, community-focused aims of our mental health planning process? The Massachusetts Comprehensive Mental Health and Mental Retardation Services Act was passed in December 1966, with the following three purposes:

- to establish a complete range of services in each community, so that every person requiring help, regardless of age or economic condition, can be cared for appropriately and quickly . . .
- to cooperate with other community agencies to provide continuity of care, especially to families being served by more than one agency
- to give people a strong voice in determining programs for their own Areas⁵⁶

A 1970 DMH brochure had this to say about children's services:

The long-range plan of the DMH is to offer a complete range of services to children, from birth to adolescence, that would include early home training for pre-school children, out-patient and day-time services, residential care, halfway houses for adolescents, and consultation, education and research. Recognizing that children 17 years of age and under constitute 40 percent of the Commonwealth's population, and services to this dependent and voiceless constituency are at present fractionated and inadequate, the DMH recommends a Child Advocate in each Area . . . [and] 1970-71 has been designated "The Year of the Child."⁵⁷

In 1972, the Task Force on Children Out of School, chaired by Hubie Jones, issued *Suffer the Children: The Politics of Mental Health in Massachusetts*. Its Foreword begins, "The report which you find . . . developed out of outrage and frustration."⁵⁸ Indeed, what follows is a searing condemnation of the DMH as mismanaged, duplicitous, and utterly uncommitted to children. Utilizing staff interviews and the department's own statistics, the report points out that only 5 percent of the DMH staff and 3 percent of its budget had been allocated for noninstitutional children's services. The document goes on to cite numerous instances in which citizen board priorities for children had been ignored and circumvented by the department. It states flatly that the DMH, "from its highest level [central office] to its lowest [areas] is controlled by psychiatrists whose training focuses them on adults . . . in institutions."⁵⁹ The report recommends an immediate investigation of the DMH for subverting the 1966 Mental Health Act and suggests numerous measures to ensure that child/family needs will be acknowledged and met.

Within five years of *Suffer the Children*, three additional groups, representing the state administration, the legislature, and a major child advocacy organization, had each surveyed the spectrum of agencies serving child and family needs.⁶⁰ All three groups issued reports citing fragmentation and duplication of services, absence of accountability, and lack of uniform standards of care. Two groups stressed the need for preventive programs and bemoaned the historical absence of priority for children in the state, as measured both fiscally and politically. They cautioned that unless the issue of priority was addressed, cosmetic organizational changes would come to naught. *The Children's Puzzle*, the report commissioned by the state legislature, put it succinctly:

There is a demonstrated ambivalence in state policy toward children. Landmark legislation enacted by the Massachusetts General Court is either underfunded or not implemented. Legislation is not implemented because of the diffusion of responsibilities between agencies or because the agencies charged with implementation are incapable of, or resistant to, following the expressed intent of the Legislature.⁶¹

Incredibly, in 1984, just seven years following the above, the state Senate felt it necessary to undertake yet another investigation of children's services, and its findings read like a carbon copy of previous efforts. It's especially interesting to see that DMH's budgetary commitment to children and families has remained the same as twelve years previously: 4 percent of total expenditures. A new and ominous note, however, is that children's services are being cut back. The governor has slashed DMH's meager budget request for children in half; DMH Central Office has reduced

its children's staff 70 percent in the previous three years.⁶² One concrete reform that did result from the Senate's efforts, however, was Executive Order 244, mandating separate hospital units for adolescents.⁶³ Like the response to Knitzer, the focus was on the most restrictive, medical — and oldest — end of children's services.

Now something funny happens. In December 1984, the secretary of Human Services had initiated the Mental Health Action Project to look into the needs of chronically mentally ill persons. The project's final report, issued in August 1985, included a detailed description of needs and available resources, as well as a set of specific recommendations. The 103-member project committee prefaced the document by stating,

The Mental Health Action Project represents an important attempt to focus attention on the needs of chronically mentally ill citizens. *It in no way diminishes the other target populations for whom the Department has statutory responsibility. Services to children and adolescents and to mentally retarded citizens continue to be areas of concern as well.* [Italics added]⁶⁴

The report goes on to articulate a mission statement for the department "in serving chronically mentally ill persons" — guiding principles, in other words, to be utilized while dealing with this population. However, the new mental health law, the State Comprehensive Mental Health Service Plan Act of 1986, limited the department's mission to the seriously and chronically mentally ill. And the Mental Health Action Project's findings were cited as the basis for this official change in direction.⁶⁵ In line with these developments, the Governor's Special Message on Mental Health (December 1985) called for major improvements in adult services, with huge amounts to be spent on renovating the state hospital system.⁶⁶ Having ignored children, families, and preventive strategies for years, contrary to statute, finally there was a legal basis for this position.

Homelessness

The other big news of the last decades, of course, has been homelessness. While the R. family was unusual in the 1970s, their counterparts became commonplace in the 1980s. In trying to figure out why this was so, we have uncovered a whole new set of gaps and declines: federal support for low-income housing dropped from \$32.2 billion to \$9.8 billion in the ten years between 1978 and 1988;⁶⁷ the median income of young parents fell 36 percent between 1974 and 1987;⁶⁸ the percentage of children growing up in poverty rose 25 percent between 1979 and 1989.⁶⁹ The job market has continued the changes begun after World War II, losing the high-paying manufacturing jobs that had provided career ladders for generations of new workers, gaining service-sector jobs that pay less yet frequently carry higher educational requirements.⁷⁰ Entitlement benefits, such as AFDC, low to begin with, have not kept pace with inflation and now average, nationwide, only 68 percent of the poverty level.⁷¹ Rents have skyrocketed. No wonder that in 1990, in 74 percent of cities surveyed, more families were requesting shelter than the year before. Or that families now comprise 34 percent of the homeless population.⁷²

And what has been our response to homelessness? Across the nation we have built shelters: emergency, short-term, longer-term, "transitional." Also, we have called for "homeless services": health care, day care, parenting programs, G.E.D.

classes, job training, counseling. While warning ourselves not to create a "homeless system,"⁷³ that is just what we've done. Not that it's a profligate enterprise. As the National Coalition for the Homeless reminds us, the sum total of expenditures under the Stewart B. McKinney Homeless Assistance Act constituted only 0.05 percent of government spending last year.⁷⁴

Nonetheless, we did at last respond where we had long been turning a deaf ear. And in so doing, we recapitulated the R. family scenario on a national level: one's plight must reach virtually ruinous proportions before we intervene. In St. Louis, for example, a Human Services Network was established, with the city planning, coordinating, and at least partially funding a continuum of residential and human services.⁷⁵ In Chicago, a large Public-Private Task Force of advocates, providers, and bureaucrats worked hard to accomplish the same goal.⁷⁶ In Portland, Oregon, existing settlement houses became large multiservice centers, blanketing city neighborhoods and attempting to maintain and provide for homeless families within their own communities.⁷⁷ Here in Massachusetts, Governor Dukakis, in his January 1983 Inaugural Address, declared homelessness to be his "number one priority,"⁷⁸ at the same time as the state was decreasing other services to families. The very year that our interagency project, the product of five years' work on the part of a city's entire child service system, couldn't scare up a dime.

Analysis

I doubt that anyone would admit to being *against* children and families. Quite the contrary, we think of ourselves as a family-centered society; we talk constantly about loving and doing for our children. By the same token, it's hard to imagine anyone being pro-homelessness, saying that there should be people without roots or a place to live. Yet our actions belie our concept of ourselves: we tolerate homelessness; it's a struggle to get any children's programs validated and funded. Even more significant, repeated attempts at reform of the child and family service system seem to go nowhere, since the same issues arise continuously, and the same kinds of recommendations keep being made. It is these two factors, the disjuncture between belief and behavior and the enduring tenacity of the behavior itself, which suggest that we must find a new way to understand what has been going on in order to be able to effect change.

Two thoughts occur to me. If it hasn't worked simply to look within the child/family system, to identify lacks and ask for redress, perhaps we need to begin by comparing children's issues with other, seemingly more valid ones, to identify the pertinent characteristics of each. What would emerge from this kind of analysis would be a set of risk factors for problematic issues; the more factors any situation contained, the less likely it would be to be addressed well, or even at all.

For example, we might juxtapose our handling of child/family issues with the way we dealt with the recent savings and loan crisis. In the latter instance, we appeared unhesitatingly willing to commit huge sums of money to correct the mistakes and misdeeds of financial entrepreneurs. Granted, there were large societal costs to consider, but there are obviously also societal bills to pay for neglecting children's health or allowing people to live in squalor. From this example, it would seem that we validate issues that involve men and/or attributes that we see as inhering in men: independence, competitiveness, action orientation, and so on. By contrast, children's issues focus on populations seen as dependent and involve interconnected groups of

people rather than individual adults. There are also ways in which the examples are similar, the most important being that we typically allow situations to fester, no matter what the specific issue. Once we do respond, however, there are vast differences in the quality of that response, depending on the problem addressed, as can be seen by comparing the amounts spent on the savings and loan bailout with the dollars we've committed to dealing with homelessness.

Because we are talking about risk factors, rather than causal relationships, as noted above, we can assume that those issues containing more negative features will be handled less well than those with fewer (and vice versa), although both will suffer to some extent. We can see this process at work by looking at the experience of different populations within the mental health and homeless systems. While all people involved with either system have been stigmatized, along with other "needy" groups, in both cases adult men were recognized and received help first. And, at least within the mental health system, men have also achieved a virtual monopoly on services.

The "risk factors" we've been discussing are really equivalent to our cultural values. In saying that the same set of beliefs underlies our treatment of children and the presence of homeless families, we are clearly implying that without some change in these attitudes and beliefs, conditions such as homelessness will continue to exist. Therefore, it seems to me that our second task is to reexamine some of these values in more detail and, using our history, to show the ways in which they appear to be affecting our policies and programs. Tenets that are laudable in theory lead to quite unexpected consequences in practice. Values that made cultural sense for a new nation may well be outmoded today.

On the eve of the twenty-first century, it appears that the frontier mentality is still with us. It is also an anachronism, but I'll come back to this later. Basically, our public ethos seems to consist of about three parts rugged individualism and one part Puritan ethic. At the top of the list is our focus on the individual. But what exactly constitutes individualism? At a minimum, that we're responsible for ourselves; that we respect those who "go for it" even at the expense of others; that we want government to leave us alone, and vice versa. Conversely, individualism implies that we don't think much of those whom we label dependent, or not responsible; that we are loath to regulate, and in fact admire people who take advantage of others; and that we resist public solutions for problems involving people. By definition, glorifying the individual means that we are less interested in families. And a focus on individual causation serves to absolve society. If fault is strictly personal, we don't need to look for societal factors and we don't need to change the way we do business. Instead, we can build asylums, and when that solution fails, we can erect hospitals. Or we can put up emergency shelters, and when they don't suffice, we can devise transitional housing.

There are two underlying implications to individualism: that the individuals in question are male and that they are also adults. Women, always by culture and usually by choice, are caretakers in society, and can rarely act independently of others. Children as well do not function on their own. Thus, we have adopted a standard that can really only apply to men, without, however, appearing to take this fact into account. And, circularly, since the ability to function independently *is* our standard, we also accept that society should focus first on the needs of those who best meet this criterion, men.

When individuals go about pursuing their interests with minimal government interference, the result, of course, is the free competitive system, the second peg in our

set of values. Once again, there is an implication to competition that we seem to lose sight of: where there are winners, there must also be losers. By stressing competition, we are ensuring that there will always be groups of people who have less than others. We are saying both that we expect losers, and that it's okay with us if they exist. And because we believe that a person's fate is within his or her own hands, when people lose, we blame them. These processes have allowed us to tolerate and rationalize disadvantaged populations among us. Taken together with our reluctance to seek government solutions, they have permitted inhumane outcomes, such as homelessness, to evolve and persist.

However, when we do create public structures, we can see the effects of competition in these as well. Nowhere is this more evident than in the perpetuation of fragmented, duplicative service systems. As we have seen, agencies and government departments are frequently assigned similar or overlapping mandates, then left to work out the details themselves, at staff, client, and citizen expense. It seems contrary to human nature, and to logic, to then expect these same entities to cooperate. Our overwhelming emphasis on competition really precludes effective collaboration and system building. It also overtly encourages splits and disagreements between people and agencies, as programs vie with one another for money and status. Having to prove continuously that they're better or more innovative in order to stay alive, agencies which should be natural allies, since they're working with the same clients and concerned about the same issues, end up as enemies. The existing system, able to offer rewards to first one and then another, emerges the constant victor.

Finally, free competition assumes a level playing field, which in fact is seldom to be found. A good example is the way in which we assign priorities to issues. We act as if all interests were equally present in the political arena, slugging it out for monetary-program prizes. Actually, some interests, such as children, cannot represent themselves at all, and others, including the poor, ethnic minorities, and women, have a diminished presence due to cultural perceptions and attitudes. When the needs of the latter populations are constantly reclassified downward, we conclude that they were simply not as pressing — each time, year after year — without stopping to look at the process.

A third fundamental precept stems from our Puritan background, adding a moralistic tinge to individualism. It holds that, just as success is the result of essential goodness, badness, or sin, underlies failure. Thus we frame solutions that are punitive: we exclude those not really deserving; we give as little as we can get away with; we try to catch people cheating. An unfortunate legacy of Puritanism is our refusal to offer true entitlements. We're so afraid of giving to a "wrong" person, thus abetting sin, that we spend countless dollars creating bureaucracies to play the role of church deacon. Unlike most of Western Europe, we have neither universal maternal and child health benefits,⁷⁹ nor a right to housing assistance.⁸⁰ Even when we enact legislation which seems to imply that right ("the general welfare and security of the Nation . . . require . . . the goal of a decent home"),⁸¹ it just doesn't happen. How ironic that the only time women were entitled to receive maternity benefits was to further the cause of war! Not for themselves, their children, or the future. It is a lesson in our real priorities to examine the life and death of this World War II program.

The last frontier principle I'd like to discuss is the need for quick, easy solutions, an imperative with great relevance for our response to homelessness. Shooting first and thinking later may have been serviceable in the Wild West when, on balance, it

was better to react quickly to an emergency, but adopting the same style in settled life distorts the sequence of events: now it takes an emergency *in order* for us to react. All kinds of consequences follow from this: we neglect issues until they turn into crises; we reinforce the squeaky-wheel approach to operating; we give time-limited responses, since attention itself relieves the emergency, and soon there's another issue whose noise level is higher. As with our other values, continuing to believe that a quick and easy style is effective and appropriate means ignoring alternative evidence and implications.

Easy solutions imply simple problems, a formulation in line with our individualistic thinking. While in fact problems involving individuals are not simple, those pertaining to families are even less so. Holding to the construct of easiness has led us to devise solutions that focus on single factors while ignoring side effects and other issues. In giving priority to homeless people over others for housing, as in New York City,⁸² we inevitably create more homeless persons. In constantly funding demonstration projects, we ensure an unstable system with lapses in service, staff turnover and unemployment, and maximal administrative and societal costs.

Quick responses share many of the characteristics of easy responses, but faith in their efficacy has an additional, critical implication: that we don't really need to plan for the long term, and therefore don't need to devise *policies*. Our lack of a child and family policy has been noted repeatedly, as has our inconsistent treatment of these populations in current laws and regulations. Refusing welfare to two-parent families is one example; splitting families to enter shelter is another. All family homelessness is a third, since no policy could possibly countenance the absence of the most basic structures for stability and growth. Without policy as our guide, each decision is ad hoc, and may or may not be consistent with the next, or the last, ad hoc solution.

Finally, there are important connections between our reliance on an emergency approach and the political process. In the more obvious sense, the two factors are mutually reinforcing, since politicians keep needing new issues, and the issues and their advocates frequently require a politician's clout. However, there is also a way in which believing that a crisis response pattern is sufficient denies the more lasting effects of the political system and ignores the degree to which politics infuses all decisions.

The history of the mental health system is testimony to the ways in which enduring vested interests maintain control over the long haul. True, there are pauses to respond to periodic crises in other spheres, as for example homelessness or even children, but the default position is clear: the system always reverts to the concerns of its male medical establishment. Depending on our figure-ground position, we can either see this as success for a crisis approach or, as I've indicated, monopolistic control by the predominant political group. Although an extreme example, because interests are rarely so narrow, the mental health system may be likened to society. We as providers may approve the crisis-oriented mode of operating simply because it seems to have worked for us, with no clue that there is also a long-term process and a more inclusive perspective. The purpose of my article is to help to provide that broader point of view and to show the very real and persistent effects of our belief system.

It has become a truism to say that those who ignore history are doomed to repeat its mistakes. Believing this, I've tried to cover enough of the past to show patterns, but clearly the account is sketchy. It's sketchy both because it's hard to encompass two hundred years in a few pages and because children's issues, like children themselves,

don't quite fit into our adult-based, vastly disjointed frameworks. The latter fact, of course, is a problem in and of itself. Since adults create the frameworks, unless they are attuned to children's issues, and the need to evolve systems that fairly reflect these factors, any "new" system will be as inadequate as the old ones.

I started with the thesis that the issue which we have named "homelessness" is not really about the condition itself. Instead, it is concerned with the ways in which we perceive and treat people, in this case children and families. I have therefore tried to chronicle and document the latter picture and present homelessness as one act in that long-running play. In another sense, homelessness more closely represents the final act, since it's hard to conceive of a condition that could encompass and symbolize neglect and devaluation more fully. As Sally Ann Hewlett has put it, we are committing national child neglect.

The first question is *Why?* Absent an overt tenet calling for the mistreatment of children and families, my answer has been that our evident and enduring behavior in this regard may best be explained as a by-product, or artifact, of other important values to which we do explicitly subscribe. This formulation would account for both the tenacity of the issue and the fact that we continue to say one thing (we love our children) and do another (neglect them).

If it is true that the problem lies in the practical workings of our basic values, then the answer to the second question, *What can we do?* begins to take shape. We, as a society, must raise our awareness of the issues involved by undergoing a sensitization process similar to that initiated some years ago by the women's movement. Sensitization differs from mere "education," or the imparting of facts. The latter is appropriate when we all start from a commonly understood base. Sensitization, rather, refers to the process by which we reach that starting point.

By raising awareness I think we will also discover that in many ways our image of ourselves is vestigial: it applies to earlier times and circumstances. It has lingered past the age that it may have been appropriate and serviceable both because of its mythic properties and because belief systems, in general, change more slowly than circumstances. Further, the demographic composition of the American populace is also changing; as early as the next century, we'll have to revise the very concept of majority and minority groups. Not only will white people be in the minority, but the people of color who constitute the majority population will consist of several quite disparate groups: blacks, Hispanics, Asians, and so on, all with different cultures, customs, and religious backgrounds. It is probable that there will be no one dominant culture in the country. Certainly, as fewer and fewer of us have any Anglo-Saxon roots at all, the Puritan ethic will become a thing of the past. To the extent that we start now to become empathic with others' issues, the imperative that has been missing thus far, we'll be ahead of the game in adjusting to such a society.

The same kinds of endemic neglect issues noted have been cast as "juvenile ageism" in an article by Jack Westman, who has also proposed another important remedy. Stating that "ageism has the virulence of racism and the pervasiveness of sexism," Westman goes on to assert that the best way to address the individual and institutional discrimination involved is through the identification and promotion of children's and parents' human rights. He calls for a new civil rights movement with a focus on children and, as I have tried to do, predicts continued dire consequences for both children and society if nothing is done.⁸³

As part of both sensitization and civil rights processes, we must also examine our

laws and policies for their real effects to children and families. We will need to continue with this procedure for each new law and regulation passed, not simply those dealing with our groups of interest, but all legislative efforts. For real decision making, we need the complete balance sheet in front us: exactly which children's programs will be cut if we spend 97 percent of our money on adults; precisely how many fewer low-income units will be available, and how many people we are agreeing should be homeless, if we cut the housing budget. Of course, impact statements have been proposed before, but at this point it has become critical to follow through with comprehensive efforts at both local and national levels.

The latter point brings up the issue of leadership. There has been considerable comment of late on the lack of dynamic leadership in the human service area. Particularly now, when a recession has been added to already deteriorating conditions, it's hard to understand the lack of outrage being expressed. It's equally difficult to account for the absence of spontaneous organizing. In the past, there have been many such efforts, as for example, welfare rights or patient liberation groups, notable now by their absence. It's almost as if we've become collectively numb from repeated blows and the lack of past success. It is my hope that the appearance of books such as Hewlett's and articles such as Westman's will begin to coalesce the necessary energy for change.

Most important, we need to develop a comprehensive policy for children and families, one which addresses all the various issues faced by this population — education, welfare, housing, social services, child care, maternity, mental health, nutrition — and fits them into a coordinated whole. A policy based on developmental need, framed in the direction of health and growth. One that will serve as the basis for our impact statements. Fortunately, we have plenty of partially used models left from the past to draw upon, since our problem has not been lack of vision, but impediments to carrying it through. Since these barriers are primarily attributes within ourselves, our job now is to face them squarely. If we don't, homelessness will be just another in a long line of catastrophic consequences for children, and for our future. ♪

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The Housing Crisis Enters the 1990s

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Homelessness in the United States is a symptom of a much deeper economic and housing crisis — a widening gap between incomes and housing prices. With the end of the Cold War, the nation has the resources to solve these problems, but to do so it must mobilize the political will. This article examines the roots of crisis, the public policies and market forces that created it, and policy recommendations to solve the problem. Key to forging a solution is building the political coalition needed to create a broad public consensus.

During the 1980s, a new ingredient was added to the landscape of America's cities — millions of people sleeping in alleyways and subways, in cars and on park benches.

The contrast of homeless Americans literally living in the shadow of luxury condos and yuppie boutiques symbolized the paradoxes of the decade: it was a period of both outrageous greed and outrageous suffering. The media gave us "lifestyles of the rich and famous," but it also offered cover stories about homeless families. And while the 1980s were often characterized as the "me decade" — an orgy of selfishness and self-interest — more Americans were involved in social issues, as volunteers and activists, than at any time in recent memory.

These contrasts are even more striking in light of the billions of dollars invested in speculative commercial real estate during the 1980s, which has led to an unprecedented high office vacancy rate. Rampant real estate speculation also contributed to the savings and loan debacle. The S and L bailout — perhaps the biggest rip-off in American history — may cost taxpayers over \$500 billion, a regressive burden that will divert funds from much needed economic and social recovery programs. Meanwhile, housing starts — particularly of low-rent apartments — have reached a post-war low while, according to a new U.S. Conference of Mayors survey, demand for emergency shelter continues to grow.¹

What will the 1990s bring?

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Everyone, from President George Bush to the late homeless advocate Mitch Snyder, has agreed that homelessness is a national tragedy and an embarrassment to America in the court of world opinion. Most Americans acknowledge that something must be done — that no great and affluent nation should tolerate such fundamental misery. Public opinion polls show that a vast majority of Americans put solving the homeless problem at the top of the national agenda. A poll sponsored by the National Housing Institute found that Americans are even willing to pay higher taxes — *if* the funds would go to assist the homeless.² And a March 1991 CBS–*New York Times* poll found that two thirds of Americans believe that the Bush administration has “not shown enough concern” to help the homeless.³

It is clear to most Americans that volunteerism alone — “a thousand points of light” — cannot stem the rising tide of homelessness. Public policy was responsible for creating this epidemic of homelessness, and it will require changes in public policy to resolve this mounting problem. But as long as politicians, housing activists, and academic experts disagree on how many people are homeless, who they are, and why America suddenly found itself with so many people living on the streets, it will be difficult to forge a consensus on what to do. In this article, we seek to answer these questions.

Dimensions of the Housing Crisis

No other major industrial nation has such widespread homelessness. Even Canada — a country quite similar to ours in most political and economic features — has neither the slums to match the physical and social deterioration of our inner cities nor the level of homeless people sleeping in shelters, streets, and subways.⁴ This suggests that there is something unique about the way the United States deals with its most needy citizens, but it also suggests that a solution is within reach. Indeed, there is no reason that the United States cannot solve its homeless problem by the end of the twentieth century — if we can mobilize the political will to do so.

The growing epidemic of homelessness is only the tip of the iceberg. The United States faces its worst housing crisis since the Depression. The underlying problem is a widening gap between what Americans can afford to pay and what it costs to build and maintain housing. This has always been a problem for the poor; now it is a growing problem for the middle class.

The American Dream of homeownership is fading fast for a large segment of the middle class. Thanks to postwar federal housing programs, the rate of homeownership rose steadily for three decades, from 43.4 percent in the late 1940s to 65.6 percent in 1980. Since then, however, it has steadily declined, reaching 63.9 percent in 1989. The problem is particularly troubling for young families. For example, among twenty-five- to twenty-nine-year-olds, the homeownership rate dropped from 38.6 to 35.3 percent from 1982 to 1989. For those between the ages of thirty and thirty-four, homeownership declined from 57.1 to 53.2 percent. In the thirty-five- to thirty-nine-year-old category, it dropped from 67.6 to 63.4 percent.⁵

A census study, *Who Can Afford to Buy a House?* explains these trends by reviewing data on housing costs and family income. According to this report, 48 percent of American families (excluding unrelated individuals) could not afford to buy a median-price house in the region where they lived. In terms of race, 43.3 percent of whites, 76.6 percent of blacks, and 74.2 percent of Hispanics are shut out of the home-buying

market. In terms of age, 71.2 percent of families headed by a twenty-five- to thirty-four-year-old, and 47.2 percent of families in the thirty-five to forty-four age category, cannot afford to buy a home. These figures include both existing owners and renters, but when the categories are broken down, the figures are even more revealing. Over one third of existing homeowners could not afford to buy a home if they wanted to purchase one today. Perhaps the most startling finding is this: 91 percent of all current renter families cannot afford to buy a home. (The figure for both black and Hispanic renters is 98 percent).⁶

The median price of a new single-family home climbed from \$69,300 in 1982 to about \$122,700 in 1990. While in 1973 it took roughly a quarter of the median income of a young family with children to carry a new mortgage on an average-price house, today it takes over half that same family's income. In some regions of the country, housing prices have started to drop, but because of wage and employment trends as well as interest rates, this has not made a significant dent in overall housing affordability.⁷

High rents make it impossible for most young families to save money for a down payment. As a result, about the only people who can afford to purchase a home are those who already own one. Even among those who manage to buy a home, a growing number are in danger of losing theirs to foreclosure by banks.

During the 1980s, rents reached a two-decade peak, according to a Harvard University study.⁸ This has been especially a problem for the poor, who are now competing with the middle class for scarce apartments. In 1989, 85 percent of all low-income renters — 5.1 million households — paid at least 30 percent of their income for housing. More than half of all poor renters — 3.5 million households — paid at least half their income just for housing. The typical young single mother pays over 70 percent of her meager income just to keep a roof over her kids' heads. Meanwhile, the number of low-rent apartments is declining, while the number of low-income renter households is growing.⁹

Apart from those who live on the streets or in shelters, there are millions more who live doubled up or tripled up in overcrowded apartments. Millions of others pay more than they can reasonably afford for substandard housing. As a result of this situation, millions of low-income Americans are only one rent increase, one hospital stay, one layoff away, from becoming homeless.

The *New York Times* reported in September 1990 a dramatic increase in doubling up among working-class families in New York.¹⁰ In January 1991, stories in the *Times* and the *Boston Globe* found, respectively, a surge of evictions and foreclosures in the suburbs surrounding New York City and a dramatic increase in evictions in Boston.¹¹

Perhaps the most important statistic is this: fewer than one fifth of poor households receive any kind of housing subsidy — the lowest level of any industrial nation in the world.¹² The swelling waiting lists for even the most deteriorated subsidized housing projects are telling evidence of the desperation of the poor in the private housing market.

Is it any wonder that the ranks of the homeless are growing?

Origins of the Crisis

The initial stereotype of a homeless person was of an alcoholic or mentally ill middle-aged man or "bag lady" — many of them victims of deinstitutionalization resulting from the Community Mental Health Act of 1963. But when more low-rent

housing was available—including many rooming houses that have been lost to gentrification—people on the margins of society could afford a roof over their heads.

The homelessness crisis is not, as some suggest, primarily a problem of personal pathology. It is, rather, a symptom of some fundamental shifts in the nation's economy. The most important involves the deindustrialization and gentrification of our urban areas. The past fifteen years have been characterized by a tremendous flight of previously high-wage industries to low-wage countries. Since the early 1970s, the electronics revolution has hastened the development of a global economy. Footloose firms have moved their manufacturing operations to locations with more favorable business conditions—low wages, lax environmental laws, tax breaks, and other subsidies—whether these be in suburbs, rural areas, or Third World countries.

As a result of this geographic realignment, it is unlikely that American industry will soon again enjoy the once privileged postwar position that enabled our standard of living to rise steadily for almost three decades. Many American cities have still not recovered from the loss of blue-collar industry and jobs. As factories closed, tax bases declined, waterfronts were left vacant, and downtown department stores went out of business, some cities began to resemble ghost towns.

During the past decade, many observers have hailed the “services revolution” as the savior of cities. It is true that many cities have shifted from what University of North Carolina sociologist John Kasarda calls “centers of production and distribution of goods to centers of administration, finance and information exchange.”¹³ Cities sought to revitalize their downtowns with new office buildings, medical and educational complexes, hotels, urban shopping malls, convention centers, and even sports complexes. But such efforts—even when successful—do not stem the growing tide of poverty only blocks away from the glittering glass and steel.¹⁴ In the shadow of its downtown skyscrapers, Los Angeles resembles a Third World city, its streets teeming with economically precarious low-wage workers and homeless men, women, and children.

Why? The service economy is predominantly a low-wage economy, and most of its jobs offer no career ladder or upward mobility. According to one major study, the majority of jobs created since the 1970s have offered poverty-level wages.¹⁵ Working full time is no longer a guarantee of escaping poverty.¹⁶ Even relatively low levels of unemployment in some cities mask the deepening poverty and desperation.

As Robert Reich noted, the American economy has two escalators—a small one moving upward and a much larger one moving downward.¹⁷ More than 33 million Americans—one out of seven—now lives below the poverty line. The figure for children is even more alarming: one out of four (and half of all black children) live in poverty. Today's poor people are poorer and likely to be poor for longer periods of time. During the 1980s, both the minimum wage and AFDC benefit levels fell far behind the rate of inflation.¹⁸

Not surprisingly, more and more of America's homeless are families with kids and people with jobs. A survey released in December 1990 by the U.S. Conference of Mayors' task force on hunger and homelessness (chaired by Boston Mayor Ray Flynn) found that almost one quarter of the homeless work, but have wages too low to afford permanent housing.¹⁹

Things are getting worse for the middle class as well as the poor. In recent years, the average middle-class American has seen family income stagnate. In 1960, the typical thirty-year-old head of household could expect family income to increase by

50 percent during the next decade. Today, he or she can expect family income (real buying power) to decline. According to the Children's Defense Fund, young families (headed by someone under thirty) have seen their incomes erode by one-quarter over the past fifteen years; among Hispanics, the decline has been one-third; among blacks, one-half.²⁰

For a small but very visible segment of the population, however, these new economic forces have led to the up escalator. The service economy has created a stratum of highly educated, well-paid management and professional-level workers. They, along with top-level executives and owners of wealth, did well during the decade of corporate takeovers and leveraged buyouts. The share of national income now going to the wealthiest 20 percent is the highest since World War II. Meanwhile, the share going to the poorest 40 percent is the lowest in that period. By dramatically lowering tax rates of the affluent and big business, the Reagan administration exacerbated these trends and redistributed income from the working class to the wealthy.²¹ President Bush's proposal to cut capital gains taxes would continue this trend.

All this pertains directly to housing. While America was witnessing a growing disparity of incomes, the affluent began viewing housing less as a home than as an investment, equally valuable for its tax benefits as for its Victorian details. Young baby-boom generation professionals moved into urban neighborhoods, especially those close to the downtown core, where they found work in the growing service sector. Housing that had been abandoned or devalued decades earlier became more attractive to so-called yuppies. As the affluent and the poor began to compete for scarce inner-city housing, prices skyrocketed. Low-rent apartments were converted to high-price condominiums. Rooming houses, the last refuge of the poor, were torn down or turned into upscale apartments. Businesses catering to the poor and working-class families were replaced by expensive shops and restaurants.

The housing market failed to significantly expand the overall number of apartments, because it simply isn't profitable to build housing for the poor. The situation was made worse when the Reagan administration removed the two props that once served to entice some private investors into providing low-rent housing — subsidies that bring housing costs and poor people's incomes into line and tax shelters that indirectly produce the same result.

The Role of Government

The dramatic escalation of housing prices during the 1980s — and the ongoing affordability gap — stems from three basic factors. First, nearly everyone involved in housing is trying to maximize profits, including land development, materials manufacture, construction, rentals, and capital gains. For example, the average price of a residential lot has increased 813 percent in the past twenty years, from \$5,200 in 1969 to \$42,300 in 1989; more than half of that increase occurred in the last five years alone.

Second, the cost of credit — the money borrowed to build and buy housing — adds a large and permanent cost to every housing unit. For homeowners, roughly two out of every three housing dollars goes to pay off a mortgage. For renters (who pay these costs indirectly), the proportion is often higher.

Third, because housing is viewed as an investment by developers, landlords, and most homeowners, home prices and rents are often much higher than what it actu-

ally costs to build and operate housing. Both homeowners and landlords expect to sell their buildings for much more than they paid for them — a psychological and economic factor known as speculation.

Government policies can exacerbate or curb these market-driven forces in three ways: subsidies, credit allocation, and regulation.

Subsidies. One way has been for the federal government to help close the gap between incomes and housing expenses through a variety of consumer and developer subsidies. The magnitude of federal housing resources was never adequate, but the Reagan administration made the situation even worse. Housing cuts shouldered the largest burden of the Reagan budget ax. Since 1981, federal housing assistance has been slashed by more than 70 percent — from about \$33 billion to about \$9 billion a year. The number of new federally subsidized apartments built each year dwindled from over 200,000 in the 1970s to fewer than 20,000 in 1990. To put this in perspective, in 1981 the federal government was spending seven dollars for defense for every dollar it spent on housing. By 1989, it spent over forty dollars on defense for every housing dollar.²²

The increase in homelessness parallels these federal housing cuts. And although President Bush and HUD secretary Jack Kemp have promised to address the nation's homelessness scandal, the Bush administration actually proposed further housing cutbacks in its 1991 budget proposal, but that was rebuffed by Congress.

The one housing subsidy that did *not* fall to the Reagan (and now Bush) budget ax is the one that goes to the very rich. The federal tax code allows homeowners to deduct all property tax and mortgage interest from their income taxes. This cost the federal government \$47 billion in 1991 alone — more than four times the HUD budget for low-income housing. Over 80 percent of the forgone tax revenue goes to the 20 percent of taxpayers who earn over \$50,000 annually; half of this subsidy goes to the 8 percent of taxpayers with incomes over \$75,000. About a third of this subsidy goes to the wealthiest 3.8 percent of taxpayers with incomes over \$100,000, and about 12 percent goes to the wealthiest one percent of taxpayers, whose incomes are over \$200,000.

Wealthy households are most likely to own homes and to itemize deductions. Over half of all homeowners do not claim deductions at all. Tenants, of course, don't even qualify. As a result, over 80 percent of households with annual incomes above \$200,000 receive a homeowner tax deduction, while fewer than one percent of households with incomes below \$10,000 get this subsidy. Only 23.4 percent of the 28.8 million households with incomes between \$30,000 and \$50,000 receive this homeowner subsidy. In other words, our nation's housing subsidies disproportionately benefit homeowners with high incomes, many of whom have two homes.²³ The *Washington Post* revealed in 1989, for example, that Senator John D. ("Jay") Rockefeller of West Virginia would receive a tax subsidy worth about \$223,000 a year just on his \$15.3 million Washington mansion.²⁴

Credit. Another housing role for federal and state governments is to guarantee a supply of credit for builders and homeowners. The government can control interest rates, require banks to meet community credit needs, and protect savings and loans to guarantee credit for the average homeowner. The Reagan administration, however, dismantled most of the federal policies designed to regulate lenders. Reagan's policies resulted in a frenzy of speculative lending, mismanagement, and corruption by the nation's savings and loan industry during the past decade. President Bush has

proposed a taxpayer bailout of failing savings and loans that looks as if it will swell to over \$500 billion.

Regulation. Finally, state and local governments can regulate land use, through zoning laws, to promote affordable housing development. Instead, most localities, particularly suburbs, use these regulations — “snob zoning” — to keep out the poor. Only a few states (New Jersey, Massachusetts, California, and most recently New Hampshire) have made any effort to address how localities use snob zoning to keep out low-income housing. State and local governments can establish codes regulating the safety and health of new and existing buildings, but few state or local governments allocate adequate resources to enforce these laws, particularly in poor neighborhoods. They can also protect consumers by regulating rents, evictions, and condominium conversions, but only a few local politicians are willing to buck the powerful real estate industry and push for these tenants’ rights laws. For example, only a handful of big cities have adopted rent control ordinances.

The Politics of Housing

In the past, the major political force for housing programs was the real estate industry — developers, mortgage bankers, landlords, and brokers. They, of course, wanted Congress to enact policies to help build more housing for the middle class or to provide subsidies to make it lucrative to house the poor. Developers, realtors, and mortgage bankers have been the most generous contributors to congressional and presidential candidates, and their national associations have strong political action committees, deep pockets, and effective local networks. In turn, many members of Congress have ties to developers and have lobbied HUD or bank regulators on their behalf.

But even the housing industry’s clout couldn’t offset the Reagan administration’s determination to slash federal housing funds, which suffered the biggest cuts of any domestic program. Some conservative politicians and editorial writers have cynically used the corruption scandal at HUD as an excuse to further dismantle federal housing programs. House minority whip Newt Gingrich, Republican of Georgia, the *Wall Street Journal*, and the *New Republic* have called for folding up HUD’s tent entirely.²⁵

Some conservatives want to replace HUD’s housing development role with a rent subsidy program, although few of them support funding it at anything close to what’s needed. A dramatic increase in rent vouchers would be an important improvement in federal housing policy. Currently, only a fraction of eligible families can obtain rent subsidies because of Washington’s failure to allocate funds. About one million low-income households now receive such vouchers, which are intended to help them pay rent for apartments in the private market; at least another seven million families are eligible.

But rent vouchers, on their own, won’t solve the problem. In cities with low rental vacancy rates, handing out vouchers is like providing food stamps when the grocery shelves are empty. During the late 1980s in Boston, for example, about half the low-income tenants who received vouchers returned them unused because apartments were so scarce. The current slack real estate market has made it somewhat easier for these tenants to find apartments, but this is a short-term phenomenon. Clearly, we must increase the overall supply of low-income housing.

The Bush administration has not acknowledged that more affordable housing is the only workable solution to homelessness. These views have been reflected in his proposed budgets, which called for significantly reduced funding for new housing,

while providing minimal increases for emergency shelters and vouchers. Congress, however, has objected to Bush's plans. In October 1990, Congress passed a housing bill that called for a slight increase in new housing funds; the president signed it the following month.

HUD secretary Jack Kemp has been a disappointment, particularly because soon after his appointment he demonstrated a strong commitment and much energy to making housing a top domestic issue. In sharp contrast to his predecessor, Samuel Pierce, Kemp has been a high-profile Cabinet member — he visits shelters, meets with advocates and builders, testifies before Congress. But despite Kemp's enthusiasm and visibility, the housing issue has not been close to the top of the Bush administration's agenda. Moreover, Kemp's overall approach to housing problems (vouchers, selling off public housing, creating "enterprise zones" in inner cities) and his defense of Bush's woefully inadequate budget proposals have not been impressive.

The Grassroots Housing Movement and Its Allies

If there was one silver lining during the 1980s housing crisis, it was the emergence of locally based efforts to address community housing needs. A combination of community organizations, municipal governments, unions, and business groups developed a wide range of innovative local programs and strategies to cope with the impact of federal housing cutbacks and changes in local housing markets. These forces gained momentum in the 1980s, in part as a result of the growing visibility of homelessness.

The fledgling grassroots housing movement is composed of tenant groups, homeless advocacy organizations, shelters and soup kitchens, church-based institutions, community-based nonprofit developers, neighborhood associations, senior citizen groups, women's organizations, and civil rights groups.

These groups have spent much of the past decade working — primarily on the local level — to plug some of the gaps left by the federal government's withdrawal from housing programs. They fix up abandoned buildings and construct new homes for the poor. They apply pressure on local governments to protect tenants against unfair evictions. They lobby for stricter enforcement of health and safety codes for "linked deposit" and "linked development" policies. They persuade banks to open branches in minority neighborhoods and increase available mortgage loans for low-income consumers. They publish reports to dramatize the plight of the homeless, the widening gap between incomes and housing prices, and the continuing practice of bank redlining. They pressure and work with city and state housing agencies to expand available funds for affordable housing and to target more assistance to community groups.

In Massachusetts, for example, these groups played a key role in pushing the state to significantly expand its housing efforts during the boom years of the 1980s. During that period, Massachusetts was frequently seen as an innovator in housing policy. But the state's current economic downturn, its fiscal crisis, and the failure of most elected officials to address these problems have led to a sweeping attack on housing and other programs. Mirroring the Reagan-era agenda in Washington, the state's housing budget under Republican governor William Weld was slashed in 1991. In response, housing advocate groups formed the HOME Coalition to develop a common agenda and a common organizing strategy to protect state housing resources and to build a stronger grassroots movement to fight for housing reform in the future.

In general, the work of grassroots housing groups around the country has been primarily defensive — brushfire battles to keep things from getting worse. Only the federal government has the resources needed to significantly address the housing and homelessness problem. Despite the good work of groups like the National Low-Income Housing Coalition, ACORN, and the National Coalition for the Homeless — and despite periodic bursts of mobilization like the Housing Now march (which brought 200,000 Americans to Washington in October 1989) — the housing movement has been relatively weak at the national level.

For the housing issue to move to the top of Congress's agenda, advocates must broaden the constituency and organize more effectively. It must mobilize people to influence members of Congress through meetings and public accountability sessions, letter-writing campaigns, and publicly rating their performance on housing issues in Congress. (In October 1990, the National Housing Institute published its "Congressional Report Card on Housing," the first analysis of votes on key housing topics).²⁶ It must do a better job at shaping the public debate, particularly getting the attention of the mainstream media to discuss alternative policies and local success stories.²⁷

Equally important, the housing movement must address the growing housing concerns of the middle class as well as the poor. As homeownership declines, and as more young adults are forced to live at home with their parents, the potential for a broad-based agenda grows. As Cushing Dolbeare, founder of the National Low-Income Housing Coalition, has pointed out, "political demographics" work against an exclusively low-income focus.

"The majority of Congress represent areas where low-income problems are not a major issue," observed Dolbeare. "Asking members of Congress to vote for low-income housing is often asking them to vote against their own political interests."²⁸

The housing agenda has always made the most headway when the concerns of the poor and the middle class were joined. In the Progressive era, that meant improving health standards for tenements for immigrant workers in the teeming slums as well as building apartment houses for the middle class. In the Depression and the post-war years, it meant building subsidized housing for the working class and shoring up homeownership for the middle class.

But the political vehicles to fashion this coalition need to be rebuilt if the issue is to move from the margins to the mainstream of the nation's agenda.

The homeless issue has brought millions of middle-class Americans face to face with the plight of the homeless. Most, of course, pass them by as they walk through the downtown sections of our cities, occasionally handing them spare change out of compassion or guilt. But a growing number of middle-class Americans meet the homeless in different settings — as volunteers in soup kitchens and shelters. They parallel the settlement house reformers who pushed for improved tenement conditions at the turn of the century and public housing during the Depression. While some of the more militant advocates for the homeless criticize the "shelter industry" as a new form of institutional oppression, most shelter staff and volunteers would like nothing more than to eliminate the need for shelters. Their concerns and political skills have yet to be effectively mobilized.

Some mayors and governors — who, as the federal government withdrew, have felt the political heat to address the homelessness problem — have become vocal allies with antipoverty and housing advocates for a stronger federal role. Boston's Mayor Ray

Flynn, for example, as head of the U.S. Conference of Mayors' task force on homelessness and hunger, helped lobby for the McKinney Act and sponsored legislation (the Community Housing Partnership Act) to provide federal funds to Community Development Corporations and other nonprofits, which passed Congress and was signed by President Bush in 1991 as part of the broader Cranston-Gonzalez housing bill.

The labor movement — once a formidable advocate for federal housing policy — has played a less active role during the past fifteen years. More recently, it has demonstrated increasing interest in the housing problem, although that is still not near the top of its agenda. Unions have begun to recognize that a renewed federal housing agenda would provide jobs, as well as homes, for its members — and for those workers it seeks to recruit. In the midst of a recession, government efforts to expand housing can be viewed not only as a “social welfare” program but also as a job-creating, antirecessionary initiative.

According to the National Association of Home Builders, the construction of one million single-family homes and apartments generates 1.3 million jobs, \$34 billion in wages, and \$14 billion in additional federal, state, and local tax revenues — and has significant ripple effects to promote economic recovery.²⁹ An August 1989 study by the Boston Redevelopment Authority examined the potential impact if 6 percent of the military budget (\$25 billion) were shifted to housing programs. The report found that Boston would get an additional \$153 million annually in housing funds, enough to meet the city's housing needs for the years 1990–2000. The funds would allow the city to subsidize construction of 4,580 low- and moderate-income housing units a year. This construction, in turn, would create approximately \$2.4 million in new annual property tax revenues for Boston and 7,400 *additional* jobs in the Boston area.³⁰

Unions are increasingly getting involved in the housing issue. In Boston, for example, the hotel workers union negotiated a contract requiring the hotels to contribute five cents an hour to a trust fund the union will use to provide housing subsidies for members. The local union waged a successful campaign to amend the Taft-Hartley Act to allow unions to bargain for housing benefits. A number of unions, including the bricklayers, have become successful nonprofit housing developers in a few cities. At the national level, the AFL-CIO was a sponsor of the October 1989 Housing Now march. Unions are beginning to look at their pension funds as a potential source of investment capital for housing; a union-sponsored conference on that topic was held in Boston in October 1991.

Some sectors of the business community are also beginning to recognize the importance of the housing problem for their own bottom lines.³¹ Like health care and child care, high housing costs are increasingly becoming a barrier to business profits. In recent years, a growing segment of the business community has become sympathetic to some version of government-sponsored universal health care and universal child care systems. As high housing prices make it increasingly difficult for employers to attract workers — creating a labor shortage in many parts of the country — key business leaders are potential advocates for a federal housing program to subsidize housing costs for low-wage workers. Business leaders in some cities have participated in public-private-community partnerships (such as the Boston Housing Partnership) to help expand low-income housing by expanding the capacity of community-based agencies. But at the national level, mainstream business groups — the U.S. Chamber of Commerce, trade associations, and others — have not yet signed on to the housing agenda.

The Progressive Housing Agenda

In light of the HUD scandal, the public is correctly skeptical of programs that offer big profits to politically connected developers and consultants in the name of housing the poor. However, the solution is not to scrap federal housing programs, but to build on the cost-effective successes that have emerged in communities across the country.

The key to a successful housing policy is to increasingly remove housing from the speculative market and transform it into limited equity, resident-controlled housing, funded through direct capital grants rather than long-term debt. That is how a significant segment of the housing industry in Canada, Sweden, and other social democratic countries is organized. In the United States, the nonprofit (or "social") sector is relatively small, but it has grown significantly during the past decade.

Congressman Ron Dellums of California already has sponsored legislation tailored to this goal. The National Comprehensive Housing Act, drafted by an Institute for Policy Studies task force, calls for an annual expenditure of \$50 billion. The federal government would make direct capital grants to nonprofit groups to build and rehabilitate affordable housing, as well as to purchase existing privately owned housing for transfer to nonprofit organizations. These homes would remain in the social sector, never again to be burdened with debt. Occupants would pay only the operating costs, which would dramatically lower the amount that poor and working-class families are currently paying for housing.

The Dellums bill is clearly a visionary program — a standard for judging progress on long-term housing goals — but not yet a winnable bill in the current political climate.

In fact, the major housing bill passed in Congress in October 1990, signed by President Bush the following month (the Cranston-Gonzalez National Affordable Housing Act), with funds appropriated the following year, provided a mix of good and bad news. After a decade of housing cutbacks, Congress finally increased the federal commitment to housing. But, after months of political wrangling, the House and Senate agreed on legislation to add only about \$3 billion to the nation's housing budget. The bill, a compromise of versions sponsored by Democratic Senator Alan Cranston of California and Democratic Congressman Henry Gonzalez of Texas, provided some funding to assist first-time homebuyers, to expand housing vouchers for the poor, to expand the capacity of nonprofit builders, to preserve the existing inventory of public and subsidized housing, and to assist residents of subsidized developments to purchase their complexes. But Congress failed to restore the federal government to the level of housing assistance of the pre-Reagan years, much less move us forward. The bill incorporated a progressive initiative, the Community Housing Partnership Act, sponsored by Democratic Congressman Joseph Kennedy of Massachusetts at the urging of Mayor Ray Flynn of Boston. It targets federal funds specifically to the nonprofit social housing sector.

In broad terms, there are five key areas in national housing policy that need to be addressed:

1. Expanding the supply of low- and moderate-income housing, particularly through the vehicle of nonprofit housing builders. We need to build at least 5 million new units (500,000 a year) this decade.

2. Preserving the existing inventory of public housing (1.3 million units) and subsidized private housing (2 million units), which are at risk from expiring subsidies and long-term neglect — and giving residents a greater role in management.

3. Providing adequate income subsidies to the 7 to 8 million low-income families who currently receive no housing assistance and cannot afford market rents.

4. Providing working-class and lower-middle-class young families opportunities for homeownership, by providing a progressive tax credit for buyers (including putting a cap on the homeownership tax subsidy for the affluent), and eliminating the existing regressive homeowner deduction.³²

5. Strengthening the government's regulation of banks and other financial institutions, particularly in terms of allocating credit for home buyers, eliminating discrimination in lending, making the wealthy pay for the S and L bailout, and putting consumer representatives on the Federal Reserve board and regional Federal Reserve banks.³³

Changes in world geopolitics — the end of the Cold War, the collapse of communism — make possible the shifting of national spending priorities that can address our domestic social and economic problems. But there is no guarantee that we'll see a "peace dividend" to invest in housing, child care, health care, education, rebuilding the infrastructure, and other much-needed domestic programs. Whether the nation's leaders seize this historic moment is a question of political will, not resources. ❧

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Homelessness

A.E.S.

Homelessness for me and many others has been and continues to be a very difficult journey. It is a hardship indeed to face hours on the street even in the best of conditions. Although we are very grateful for the services of various soup kitchens, it would be a real luxury to be able to choose and prepare our own menus and eat at the hours we feel appropriate.

Some of us tend to be really impatient under these conditions, either waiting for an empty seat in the church hall or receiving food that doesn't taste the way we would like to have it prepared or maybe there is something personal going on with us and we tend to be unpleasant to be around.

Some of the questions that go through our heads are: "Where do we go after this?" "When can we get a place to call our own?" "Does anyone really want us?" "Why are we looked down on?" "Where can I find a place to take a bath?" "Where can I catch 40 winks?"

For me the question is "Where is that place where I can be alone with someone I am really close to?"

Please God help us to realize that there is a place for us somewhere. Help us to realize that someone does care. Help us to know that "Homelessness" doesn't have to lead to "Hopelessness." You are not going to give up on us. We can be loved. 🙏

Shelter the American Way

Federal Urban Housing Policy, 1900–1980

Ronald Dale Karr

American urban housing policy has featured subsidies for the suburban middle class and parsimonious spending for the urban poor. The outlines of this policy took shape during the Progressive Era: acceptance of the capitalistic market economy, support for the deserving poor needing temporary help, toleration of racial segregation, and the designation of overcrowding as the single most important urban problem. Progressive housing reformers championed stricter housing codes and model tenements, but housing conditions for the urban poor showed little improvement.

The U.S. government avoided direct involvement in housing until the early 1920s, when it promoted local zoning legislation. Under the New Deal, the government aided the private housing industry, but housing for the urban poor was not addressed until the passage of the Wagner Housing Act in 1937, which authorized federal funds for public housing. Although the worst features of public housing had been improved by the 1970s, the legacy of limited funding, racism, and the belief that subsidized housing for the poor should not compete with private-sector middle-class housing kept millions of Americans poorly housed.

The Congress hereby declares that the general welfare and security of the Nation and the health and living standards of its people require . . . the realization as soon as feasible of the goal of a decent home and suitable living environment for every American family.

— Housing Act of 1949

The upsurge in urban homelessness in the 1980s was yet another confirmation of the failure of American housing policy to achieve the goal of decent shelter for all its citizens. Despite decades of affluence and aggressive eradication campaigns, slums persisted, made even more frightful by drug-related violence. Millions continued to inhabit these dangerous neighborhoods.

In 1980 nearly two thirds of all Americans owned their homes — about twice the rate of Western Europe. At the same time, according to Kenneth Jackson, “public

housing accounted for only about one percent of the United States housing market [but] it comprised 46 percent of the market in England and Wales, and 37 percent of the French housing market."¹ Widespread home ownership for the suburban middle class and parsimonious spending on public housing for the urban poor are but two aspects of federal urban housing policy.

Progressivism and the Beginnings of Housing Reform

Direct federal involvement in urban housing was a product of the New Deal, but a national policy had its origins a generation sooner. As early as the 1820s, many in the middle and upper classes had been troubled by urban poverty. Most of these city residents, the products of villages or farms, keenly felt the loss of the moral order of the communities in which they had been raised. Reformers launched religious revivals and Sunday schools, and later, parks, playgrounds, and organized charities, all in hope of redeeming the urban masses. The reformers attributed poverty to moral defects, such as intemperance, laziness, or stupidity (or even Catholicism), in the poor themselves.²

The modern American housing movement emerged at the end of the nineteenth century as part of the great wave of reform, the Progressive movement. New York, the nation's largest city, was home to the republic's most notorious slums. Hideously overcrowded blocks of five- and six-story tenements, most with only primitive sanitation, housed more than a million people on Manhattan. Housing crusaders, led by Jacob Riis and Lawrence Veiller, sought to stop the construction of new slums through building codes and to force slumlords to upgrade existing tenements through housing regulations. Although previous reformers had passed a tenement law by 1867, shortcomings in the act itself and lax enforcement made it ineffective. In 1901 the reformers finally put through a much stronger law and obtained the means to enforce it.³

Other housing reformers, taking a different tack, proposed that philanthropic individuals and organizations construct model tenements incorporating high design and construction standards. These would then be leased at the prevailing rents, giving the tenants more for their money and providing a moderate (4 to 6 percent) profit for the owners. A number of cities saw such projects constructed in the last quarter of the nineteenth century. Model tenements would directly provide better housing for their fortunate occupants and, more important, by example pressure other builders to construct to the same standard.⁴

By 1910 the various housing reformers of New York, Boston, Philadelphia, Chicago, and other large cities were beginning to operate in concert. That year the National Housing Association was founded, with New York's Lawrence Veiller as its director, to encourage cities to investigate slum conditions and enact housing and building codes. Others, with less formal organization, promoted the model tenement.⁵

The Progressive housing movement does not seem to have been particularly controversial; indeed, apathy appears to have been its most serious opponent.⁶ The wide acceptance — or at least toleration — of these housing reformers contrasts sharply with the intense controversy their successors have generated from the New Deal to the present. The most probable reason for the support the movement enjoyed is that Progressive views on the housing problem were shared by vast segments of the American middle class.

The ideological assumptions of the Progressives are worth examining, since they continued to influence later generations of housing reformers. Many of their views have gradually been modified or abandoned, but echoes of them can be heard today, and there is reason to suspect that much of the American public still endorses these beliefs.

Capitalism

Although aware of its shortcomings, Progressives embraced free enterprise. They sought to eliminate the waste and inefficiency that produced some of its more damaging effects on society. They accepted the marketplace — if kept free of monopoly and conspiracy — as an effective allocator of resources, and for the most part did not believe that government should compete with private companies. Lawrence Veiller rejected public ownership or even subsidies of housing.⁷ Many of the strongest supporters of Progressive urban reform, particularly at the local level, were businessmen or corporate lawyers.⁸

Progressives rejected the idea of *laissez-faire*, believing that businesses, like all social institutions, should be subject to wholesome regulation. Many businessmen agreed, hoping that the government could bring a stable and profitable order to the chaotic competitive environment in which they operated. Even in the heyday of *laissez-faire*, the late 1860s and 1870s, the older Whig-Republican idea that the government should promote, protect, and even subsidize private enterprise persisted, and Progressives, often of Republican background, could live with this aid so long as it promoted the general welfare.⁹

Progressives were quick to attribute social problems to evil individuals instead of holding the capitalistic system to blame. Muckrakers enraged Progressive audiences with vivid accounts of greedy big businessmen contemptuous of the public weal. Since slumlords caused slums, code enforcement for the recalcitrant and the example of model tenements for the penitent would presumably eradicate the evil.¹⁰

Poverty

Before the Progressive era, most reformers believed that poverty usually resulted from individual depravity. In this they shared the popular view, which was, according to Robert Bremner, that

poverty is unnecessary (for Americans), but the varying ability and virtue of men make its presence inevitable; this is a desirable state of affairs, since without the fear of want the masses would not work and there would be no incentive for the able to demonstrate their superiority; where it exists, poverty is usually a temporary problem and, both in its cause and cure, it is always an individual matter.¹¹

The rapid growth of urban slums and the frightening depressions in post-Civil War America made it increasingly difficult for reformers to hold on to this view. The unhealthy slum environment itself might be a cause of poverty as well as a result. By 1900, reformers were shifting their efforts from reforming the individual to remaking the social environment. It had long been recognized that some of the poor — that is, virtuous widows — might not be responsible for their plight, but the numbers of “deserving poor” were felt to be small. Now it began to be accepted that the bulk of the poor were not fully responsible for their condition. The challenge was to iden-

tify and assist them without being generous to the point of corrupting their morals and leaving them permanently dependent.¹²

Progressives thus believed that most of the poor were potentially bourgeois, members of what Lawrence Friedman has termed "the submerged middle class."¹³ Improving the environment by rebuilding the slums, providing parks and playgrounds, and eliminating saloons and prostitution would effectively end poverty, except for the chronically vicious, who would be institutionalized. By 1910, however, some Progressives were realizing that additional measures, such as social insurance, child labor laws, and higher wages, would be needed, and that the elimination of poverty was more difficult than they had once believed.¹⁴

Racism

The Progressive movement coincided with the high water mark of American racism. Segregation swept the South, the disenfranchisement of black voters was nearly complete, and lynchings and race riots occurred with sickening frequency. Pseudo-scientific cant reached the point at which non-Anglo-Saxon Caucasians were held to be racially inferior. With a few prominent exceptions, Progressives at least tolerated segregation. Housing reformers would not actively strive for equal treatment of minorities until well into the 1950s.¹⁵

Congestion

Progressive housing reformers regarded overcrowding as the most serious single urban problem. New York City tenements packed twenty-four families onto a twenty-five-hundred-square-foot lot, and some parts of Manhattan were among the most crowded spots on the planet.¹⁶ As early as the 1840s, suburbanization was being advocated as one solution for excessive residential density.¹⁷

A half century later, suburbs bloomed and urban congestion remained, but the lure of the fringe remained strong. "The metropolis of the future," the Massachusetts Rapid Transit Commission forecast in 1892, would be "a city closely built, and during the daytime densely populated, this surrounded by a semirural district, in which are the homes of those who work in the city, but who pass their nights, and whose families pass their lives, under the purer and healthier influences of the country." With better transit even the workingman would be able to "abandon the unhealthy and demoralizing life of the tenement-house, and obtain for himself and family the benefits of a suburban home."¹⁸ The pioneering urbanologist Adna Webber concluded his monumental study, *The Growth of Cities in the Nineteenth Century* (1899), by noting that "the most encouraging feature" of recent years was "the tendency . . . toward the development of suburban towns."¹⁹

Not surprisingly, Progressives welcomed the automobile and championed the Garden City movement, which proposed building new, low-density cities with limited populations.²⁰ Progressive housing reformers generally supported home ownership and the single or two-family house as promoting the best middle-class values and giving individuals a stake in the social order. Several model housing schemes employed individual homes, detached or semidetached, instead of tenements.²¹ Still, most probably wondered if suburbanization would ever significantly reduce urban density, as had Jacob Riis when he wrote in *How the Other Half Lives* (1890): "Workingmen, in New York at all events, will live near their work, no matter at what sacri-

fice of comfort — one might almost say at whatever cost, and the city will never be less crowded than it is.”²²

For all its efforts, the Progressive housing movement failed. The slums remained. Negative reforms, such as tenement codes, raised the quality of new construction and helped upgrade older units, but they could not significantly improve the stock of urban housing. Rigid enforcement of the laws against overcrowding would literally push people out into the street. Higher building standards meant higher costs and, ultimately, higher rents. The dilemma was that increasing the *quality* of housing threatened to reduce the *quantity* available, especially to the poorest residents.²³

The other Progressive housing measures, the model tenements, and the attempts to improve the general neighborhood environment through parks, playgrounds, and vice control, met with no greater success. Model tenements provided tenants with quarters superior to what they otherwise could rent, but too few were ever built to have much of an effect on the slums. Individual landlords, even if they had wanted to, rarely had the financial resources to invest in large-scale model tenements. Most slumlords were small operators, often immigrants themselves, not large institutions or wealthy rentiers. As buildings deteriorated, there was a “filtering down” of landlords, as ever poorer landlords followed ever poorer tenants.²⁴

With all its failings, the Progressive housing movement had launched an effort of great vigor whose effects have been felt ever since. The housing codes remained, paving the way for such later regulations as zoning and subdivision control. Echoes of the model tenement continue to be heard today.

The Emergence of Federal Housing Policy: The 1920s

In 1916, the city of New York enacted the nation’s first zoning law. Zoning, which originated in German cities around 1900, was adopted in New York following several years of study, when fashionable Fifth Avenue merchants wanted to restrict the spread of garment factories near their stores. In its sweeping restrictions on land use it was the most radical departure from traditional American real estate practice to that time.²⁵

This major break with *laissez-faire* was promoted by conservative business and real estate interests seeking to stabilize the land market. Whatever potentially radical effects zoning might have had were curtailed when it was separated at birth from the process of planning. Zoning was destined to become a tool of politicians, lawyers, and land developers, not comprehensive planners.²⁶

The novelty of this new regulation in the nation’s most important city could not help but attract national attention, and the law’s authors, like Lawrence Veiller, did all they could to encourage other cities, large and small, to adopt zoning. In part this was done in hopes of strengthening the city’s position when the law faced its inevitable court challenges. The Supreme Court was a bastion of traditional conservatism, and despite the conservative intentions of the law, there were fears that the Court would find that zoning constituted a taking, which would require compensation to property owners.²⁷

Until 1921, the federal government had only one brief involvement with housing. During 1918 the government had constructed nearly 25,000 units of rental housing

for war workers, but Congress ordered their sale shortly after the end of the fighting. Staffed by imaginative architects and planners, the U.S. Housing Corporation and the Emergency Fleet Corporation produced housing of a surprisingly high quality and served as a direct inspiration for public housing advocates in the 1930s.²⁸ The government's reinvolvement with housing began when Secretary of Commerce Herbert Hoover sought to stimulate the real estate and construction industries by setting up the Division of Building and Housing within the Bureau of Standards. Hoover saw that housing prices put the average new house well beyond the budget of the typical worker. His strategy was to help the construction industry reduce costs through greater standardization of materials, which the government could encourage. He also discovered the New York-led zoning movement.²⁹

In 1921 Hoover named an Advisory Committee on Zoning, dominated by Veiller and other New York zoners. The following year the committee issued its influential *Standard State Zoning Enabling Act*, based heavily on the New York statute. The government sold more than 55,000 copies, and a year later nearly a dozen states had enacted similar laws.³⁰

With the official endorsement of the federal government, zoning spread from coast to coast. By the end of the decade nearly eight hundred cities and towns had adopted zoning.³¹ This popular acceptance doubtlessly played a part in the somewhat surprising decision of the U.S. Supreme Court in 1926 when, in *Euclid v. Ambler*, by a 6 to 3 vote, it upheld zoning. In its decision, written by ultraconservative Justice George Sutherland, the Court endorsed the idea that multifamily housing (which it termed commercial) ought to be excluded from single- and two-family residential districts.

The development of detached house sections is greatly retarded by the coming of apartment houses, which has sometimes resulted in destroying the entire section for private house purposes . . . In such sections very often the apartment house is a mere parasite, constructed in order to take advantage of the open spaces and attractive surroundings created by the residential character of the district. Moreover, the coming of one apartment house is followed by others . . . bringing . . . the disturbing noises incident to increased traffic and business, and the occupation, by means of moving and parked automobiles, of larger portions of the streets, thus detracting from their safety and depriving children of the privilege of quiet and open spaces for play, enjoyed by those in more favored localities — until, finally, the residential character of the neighborhood and its desirability as a place of detached residences are utterly destroyed.³²

With a seal of approval from the judicial branch of the federal government, zoning's future was assured.³³

By promising stability for investors, zoning helped rationalize real estate and stimulated housing, as well as helping to launch the great speculative construction boom that finally helped bring down the entire economy in 1929.³⁴

Housing and the New Deal

As secretary of Commerce for two weak presidents, Herbert Hoover was largely responsible for federal economic policy in the 1920s, and he reaped the results as president in the early 1930s. Once the severity of the Depression became known, attempts were made to prop up the construction and banking industries, but to little

avail. By 1933, when Hoover left office, half the mortgages in the country were in default, and a thousand properties were being foreclosed daily.³⁵

In this atmosphere of deep crisis, the administration of newly elected Franklin D. Roosevelt was able to make an unprecedented intervention into the home financing system. On June 13, 1933, the Home Owners Loan Corporation (HOLC) was created to refinance existing home mortgages in danger of foreclosure. More than a million mortgages were written. The HOLC pioneered the use of the long-term, self-amortizing mortgage (hitherto, the typical home mortgage was from five to ten years, with a balloon payment due at the end, usually requiring periodic refinancing).³⁶

A year later, on June 27, 1934, President Roosevelt signed the National Housing Act, which created the Federal Housing Administration (FHA). "No agency of the United States government," observed Kenneth Jackson, "has had a more pervasive and powerful impact on the American people over the past half-century." The FHA was intended to stimulate the moribund housing industry by insuring new mortgages. It was one of the most successful of all New Deal measures: housing starts, which nearly doubled between 1937 and 1941, zoomed after the end of World War II; "Between 1934 and 1972, the percentage of American families living in owner-occupied dwellings rose from 44 percent to 63 percent." And for this the FHA could well take credit: by 1972 it had insured over 11 million mortgages. Taking the long-term, self-amortizing mortgage from the HOLC, it also promoted minimum home construction standards that swept the home-building industry.³⁷

Most new housing after 1937 was in the suburbs, which often were unprepared for the enormous growth the FHA directed their way. But the FHA was a veritable disaster for older cities, which received few FHA-guaranteed loans. Taking its cue from the Progressive housing reformers the FHA was partial to the owner-occupied, single-family house and far readier to insure loans for them than for multifamily rental properties. With a nod to home builders, the FHA made it easier to buy new homes than to rehabilitate older ones. And most important, the FHA based its decisions on whether to insure a mortgage on factors that discriminated against houses in older built-up areas. The FHA openly endorsed racial segregation until the 1950s and generally refused loans to areas characterized by "inharmonious racial or nationality groups"; its *Underwriting Manual* "read like a chapter from Hitler's Nuremberg Laws."³⁸ The resulting "redlining" — in which certain urban neighborhoods were written off as too risky for loan guarantees — became self-fulfilling prophecy, as private lenders followed the lead of the FHA and shut off credit, making it virtually impossible for applicants to get mortgages for rehabilitation or building loans.³⁹

Until World War I, builders constructed new housing for all income levels, from mansions to tenements, but after 1920 they concentrated on the top half — or even top third — of the market by income groups, where profits were greatest. By 1935 the slums were not simply crowded and poorly maintained but also old; new tenements had not been built in nearly a generation.⁴⁰ Although such Progressives as Lawrence Veiller had rejected publicly subsidized or owned housing, by 1919 a few, like Edith Elmer Wood, began calling for governments to construct low-income housing and clear slums. In the 1920s, Wood joined up with Clarence Stein, Lewis Mumford, and others of the Regional Planning Association of America (RPAA), some of whom had designed government-built war housing in 1918, in helping to launch organizations to lobby for legislation.⁴¹

Most of the early housing efforts of the New Deal in Roosevelt's first term (1933–1936) were aimed at propping up particular industries — such as homebuilding, real estate, and banking. Of a rural background, Roosevelt had only limited personal knowledge of and interest in urban issues. Low-income-housing advocates had little success in securing government support. The National Industrial Recovery Act (NIRA) of 1933 authorized the Public Works Administration (PWA) to build public housing and clear slums, but only a limited number of units were produced under this emergency legislation. Intense lobbying efforts by advocates such as Woods and Catherine Bauer secured strong support from organized labor and at last won the reluctant endorsement of the president. Following his triumphant reelection in 1936, Roosevelt endorsed a housing bill previously introduced by Senator Robert F. Wagner of New York. Large majorities of both houses of Congress passed the legislation, and the president signed the Housing Act on September 1, 1937.⁴²

The Wagner Act set the pattern followed by subsequent housing legislation. Under its provisions the U.S. Housing Authority was established to subsidize local housing authorities. These locally organized and controlled bodies borrowed money from the federal government to build public housing units. Tenant rent covered out-of-pocket operating costs while annual subsidies from Washington paid off the loans. This reliance on rent payments, as Lawrence Friedman noted,

would . . . tend to restrict public housing to the honest, working poor. Dependent families, families with no incomes, and problem families would usually be too poor for public housing. . . . The projects would mainly be filled with deserving but underpaid workers — innocent victims of economic reverses, who need a “break” to tide them over the lean years.⁴³

At the same time, upper-income limits kept out those who could afford private housing, thus deferring the government from competing with the private sector. To prevent extravagance, conservatives had tacked on a requirement that costs not exceed \$4,000 per unit (\$5,000 in large cities). Finally, the act provided for the old Progressive goal of slum clearance by requiring that for each unit constructed a unit of substandard housing be eliminated. Thus the overall housing stock would not increase, but at a time when many buildings were vacant due to lack of tenants who could afford the rent, this did not seem unreasonable.⁴⁴

Between 1937 and 1941, the U.S. Housing Authority funded 300 projects resulting in 130,000 units of new low-income housing. At the same time, 79,000 units of older substandard housing were demolished or upgraded. Although these projects were large in overall size, one- to three-story buildings were the norm (only a small fraction contained buildings with more than five floors). Unlike the crowded tenements they replaced, the new housing featured open space, playgrounds, and meeting rooms. Housing reformers like Wood and Bauer were able to influence design standards and operating policies to support the family life of the poor.⁴⁵

Later legislation and changes in administrative procedures would modify this initial housing policy, often for the worse, making the shortcomings of public housing painfully obvious. But in retrospect the Wagner Act itself was deeply flawed. The law's construction cost limits reflected in part the traditional American attitude toward charity, inherited and transmitted by the Progressives, that dependency must be discouraged. Boston's Josephine Shaw Lowell, in 1884, put it succinctly: “Relief should be surrounded by circumstances that shall . . . repel everyone, not in extrem-

ity, from accepting it.”⁴⁶ Congress, explained Lawrence Friedman, “did not want its public housing, any more than its jails, to be luxurious. Congress wanted public housing to act as a way station for the temporarily dispossessed; it was to be a ‘slum of hope,’ but without peeling plaster and nauseous privies.”⁴⁷ Millions of working-class American taxpayers who were ineligible for public housing would have been outraged to see poorer people enjoying better quarters at their expense.⁴⁸

These attitudes virtually assured that American public housing would be unattractive, if not repulsively grim. Public housing *had* to look like public housing. Unfortunately, Congress attempted to limit “luxury” features by clamping down on construction costs, apparently not realizing that amenities in fact made up a relatively minor part of overall development expenses. The result was to encourage builders to reduce basic construction quality, not simply skip “frills.” Thus the Wagner Act was a blueprint for dreary, cheaply built structures housing a transient population striving to escape the stigma of charity by leaving as quickly as possible.⁴⁹ No wonder that most neighborhoods and communities would as soon embrace public housing as a prison or a pesthouse.

Realizing that public housing might prove unpopular, Congress made it entirely voluntary. Any municipality could reject it altogether by simply failing to establish a housing authority, and for those which did want some subsidized housing, the local authority, not the federal government, decided where it would go. In Chicago, for example, each alderman had veto power over projects in his ward. In addition, by requiring that one unit of substandard housing be eliminated for each constructed *in the same community*, the law guaranteed that public housing could never be built on cheaper vacant land on the urban fringe but only in the older inner-city neighborhoods where the poor already lived.⁵⁰

The entry of the United States into World War II in December 1941 brought an end to the initial phase of federally funded public housing construction. New low-income housing projects were canceled as priorities shifted, as they had in World War I, to housing war workers. The New Deal was over, but its housing legacy — particularly the FHA and the Wagner Act — would have a powerful effect on the shape of the nation after the war.

From the Fair Deal to the Great Society

In 1945 the nation faced an acute housing shortage. The overheated war economy had left Americans flush with cash, which they were anxious to spend on houses, cars, and other goods. The government rewarded the 16 million war veterans (and voters) with the Serviceman’s Readjustment Act of 1944 (the GI Bill), which, among other things, created the Veterans Administration (VA). The VA worked in close association with the FHA to guarantee mortgages for ex-servicemen, and it adopted the latter’s policies. Together the FHA and the VA helped finance the construction of millions of units of new housing, mostly single-family and in the suburbs. Mass-market building techniques and low-interest loans brought monthly costs of new homes below average rents.⁵¹

At least partly as a result of these policies, the cities were losing their middle classes to the burgeoning suburbs. Former residents of public housing were leaving for the vacated middle-class urban neighborhoods or even the suburbs themselves. At the same time, poor rural migrants, particularly southern blacks, Puerto Ricans

and other Hispanics, and Appalachian whites, were seeking shelter in the old urban slums.⁵²

This put administrators of public housing in a dilemma. Public housing was intended to serve as temporary quarters for the “submerged middle class,” the hard-working poor on their way to respectability, not as permanent homes for the lowest-income poor. Yet it was this underclass that was most in need of a place to live, at a time when the prewar tenants could afford to leave. The inevitable result was a major shift in tenant selection policy whereby welfare recipients came to constitute an increasing proportion of public housing occupants.⁵³

At the same time, the return to prosperity in the 1940s eroded political support for public housing. Federal funding for new nondefense housing projects ended in 1942, and an increasingly conservative Congress would not authorize resumption of the program. President Harry Truman made federal aid for housing part of his Fair Deal program, but the capture of Congress in 1946 by conservative Republicans generally hostile to public housing put the program on the defensive. In a surprising move, Senator Robert Taft, a conservative Republican from Ohio, agreed to sponsor housing legislation acceptable to the Truman administration. But passage of this bill had to wait until after Truman’s unexpected election victory in 1948, which again produced a Democratic Congress.

After four years of effort, the so-called Taft-Ellender-Wagner Housing Act was signed by President Truman on July 15, 1949. It officially committed the nation to “the goal of a decent home and a suitable living environment for every American family.” The public housing program of the Wagner Act was revived, with 810,000 units of housing authorized for the next six years (this provision had survived the House of Representatives by only five votes). Finally, it authorized a massive program of urban redevelopment.⁵⁴

Slum clearance had been a major objective of housing reformers since the Progressives, but demolishing blighted areas appealed to many with scant interest in housing for the poor. Real estate interests, bankers, and businessmen were dismayed to watch their investments in urban land go sour, while urban planners dreamed of rebuilding cities. Public housing advocates, realizing that removing slums was far more popular than rehousing the poor, saw no choice but to link the two, including in the housing bill a slum clearance measure originally written by the real estate lobby so hostile to public housing. Title I of the 1949 Housing Act authorized cities to create Urban Redevelopment Authorities armed with powers of eminent domain to condemn blighted areas. They would acquire the properties, demolish the buildings, and resell the land, below cost, to private developers.⁵⁵

Title I, along with its successor, the 1954 Housing Act (in which urban redevelopment became urban renewal), changed the face of urban America. Unfortunately, the poor gained little from the massive rebuilding that occurred. The law attempted to link redevelopment to housing by requiring that redevelopment projects be confined to currently residential districts or areas that would become so after development. But it did not require that any new housing result. Developers could — and did — tear down residential neighborhoods and replace them with stores, luxury hotels, and even parking lots. What housing was built through redevelopment was usually too expensive for displaced residents. And sometimes the demolished neighborhoods, like the West End of Boston, were not even slums, just older areas that became attractive to well-connected developers.⁵⁶

Politics in the 1950s was dominated by conservatives, most notably President Dwight Eisenhower. Public housing was under constant attack in Congress. Eleven years after Congress authorized 810,000 units of public housing, it had voted funds for only 322,000.⁵⁷ With funding limited, housing administrators sought to cut construction costs. Most prewar projects were one to three stories high; now, soaring land costs and dwindling appropriations made the high rise symbolic of public housing.⁵⁸ As part of the 1949 act, housing administrators were forbidden to discriminate against welfare recipients (although racial discrimination was permitted), and public housing tenants increasingly were among the poorest of the poor.⁵⁹ Meanwhile, urban renewal, along with highway construction in the wake of the Interstate Highway Act of 1956, displaced large numbers of the poor without providing sufficient replacement housing. The remaining slums became more crowded, and derelict buildings were given new leases on life.⁶⁰

By the early 1960s, critics, conservative and liberal, assaulted public housing. Catherine Bauer, one of the prime movers behind the Wagner Act, noted angrily, in 1957, that "life in the usual public housing project is not the way most American families want to live."⁶¹ "Low-income projects," Jane Jacobs wrote in her influential *The Death and Life of Great Cities* (1961), have "become worse centers of delinquency, vandalism, and general social hopelessness than the slums they were supposed to replace."⁶² Various pieces of housing legislation were enacted to correct some of the worst abuses, but the basic system remained unchanged. Although Democratic, the Kennedy administration did not establish a strong low-income housing program. The general unpopularity of housing projects kept new subsidized housing units to only 24,000 a year during the Kennedy years, fewer than under Eisenhower.⁶³

On becoming president in 1963, Lyndon Johnson attempted to implement a second New Deal, which he styled the Great Society. Urban housing was not a high point on his original agenda, but the Housing and Urban Development Act of 1965, which he put through Congress after his smashing electoral victory, authorized 60,000 new units of public housing a year for four years, more funds for urban renewal, and a new program of rent supplements for poor individuals to subsidize rents in private housing. (LBJ had wanted this to go to the working poor ineligible for public housing, but Congress restricted it to *only* those eligible for public housing. After authorizing the program, Congress blocked funding for it owing to fears that it would bring public housing to white suburbs.) Johnson also obtained long-sought recognition for housing problems when the cabinet-level Department of Housing and Urban Development was approved by Congress in 1965.⁶⁴

Beginning that same year, insurrection swept the ghettos of America's largest cities, the worst riots occurring in the summer of 1967 in Detroit and Newark and, after the assassination of Martin Luther King, in 1968. With an urban crisis clearly at hand, Johnson was able to get Congress to pass another housing bill. The Housing Act of 1968 authorized an incredible 600,000 units of low-income housing (using the same basic funding scheme as in previous housing acts) for the next three years. In the first year, Congress appropriated money for only 100,000 units, still a sharp increase over previous years. It also set up two alternatives to traditional public housing: rent subsidies for limited dividend profit-making or nonprofit developments (Section 236) and an attempt to promote home ownership by mortgage payment subsidies (Section 235).⁶⁵

Housing Policy in the 1970s: Transformation and Decline

The war in Vietnam derailed the Great Society, along with the political career of its author. Because of the programs put in place, however, the greatest construction surge of new subsidized housing occurred during the first administration of Richard Nixon. In 1970, more than 90,000 units of conventional public housing were added, along with nearly 120,000 rent-subsidized units and 150,000 Section 235 mortgages. The surge was short lived. On January 8, 1973, just after Nixon buried George McGovern in the 1972 presidential election, the administration announced a freeze on all housing programs pending further study. Nixon was then at the height of his popularity, the urban crisis attitude of the 1960s had faded, and austerity was in the air.⁶⁶

By 1973 some of the worst features of low-income housing policy had been addressed. Since 1966 the FHA had aggressively sought urban mortgages and redlining decreased (critics charged, however, that this merely made it easier for whites to flee the city).⁶⁷ High rises were out of fashion, and the new emphasis was on smaller "scatter-site" projects located away from the ghetto. Rent-subsidized projects could include mixtures of subsidized and market-rent units. But the negative image of three decades of American public housing could not be shaken. In 1972, newspapers from coast to coast carried photos of the demolition of St. Louis's notorious fifteen-year-old Pruitt-Iggoe project. At the same time, reports surfaced of widespread abuses involving FHA and Section 235 mortgages.⁶⁸

In 1974, shortly before his resignation, Nixon canceled his freeze on new housing projects. One of the first acts of his successor, Gerald Ford, was to sign the Housing and Community Development Act of 1974, the only major housing legislation of the decade. Under this act the subsidy of private construction programs was renamed Section 8 and broadened. After a year and a half of the freeze on housing programs, low-income housing construction resumed, but it never reached the peak of the early Nixon years.

By the time Jimmy Carter took office in 1977, subsidized Section 8 projects had almost entirely succeeded conventional public housing. Unlike his liberal Democratic predecessors, Carter did not seek new housing initiatives. Stymied by a stagnant economy, Carter was anxious to restrain federal expenditures, and the number of subsidized units declined. By 1979 the bulk of the new low-income housing was earmarked for the elderly, such projects having proved acceptable even in suburbia. Only a small portion of what remained of the low-income program was available to low-income urban families.⁶⁹ The cumulative effect of decades of urban renewal and the failure to provide sufficient amounts of quality low-income public housing were having a devastating impact on the urban poor. With affordable housing ever scarcer, homelessness was on the rise, a process that became even more critical after Ronald Reagan entered the White House in 1981.⁷⁰

In 1964, the *New York Times* observed that "traditionally, housing bills have been an uneasy compromise between the demands of the private real estate industry and the moral claims of the slum-dwellers, the elderly and the minority groups, with Congress usually more responsive to the former than to the latter."⁷¹ Until well into the 1960s, housing advocates directly descended from the initial Progressive reformers spoke for the consumers of public housing. Federal housing policy was a constant struggle

involving the president and executive agencies, Congress, and the courts, with lobbyists from many quarters and public opinion hovering in the background.

The basic Progressive tenets, widely held among the American middle class, guided that policy. Dispersal of population was good, at least for the middle class; federal policy helped middle-class whites move to suburbia while increasingly isolating the minority poor who remained behind in the cities. Public housing never really had a reasonable chance of success. It was expected to be an improvement over the slums, but without frills that would corrupt the character of its tenants or excite the envy of taxpayers; it had to be repulsive enough to discourage long-term occupancy, yet somehow foster a sense of community among its transient occupants; it was intended for the short-term working poor, but sited, designed, administered, and funded to become the permanent home of the very poor.

Early housing reformers rarely considered the problem of the “undeserving poor” — drug addicts, single mothers dependent on welfare, alcoholics, foreigners unwilling to learn English, criminals, and the chronically lazy. Public housing, designed for others, ended up taking these individuals in because our system had made no other provision for them and because often no one else wanted to live there.

Federal housing policy, of course, is not a story of unrelieved disaster even for the poor. Hundreds of thousands of people took shelter in public housing, and many projects, particularly more recent smaller ones, were well run. Still, the failure after more than half a century to develop a satisfactory housing policy inspires scant confidence that the narrower problem of homelessness will ever be addressed effectively by our federal government. 🐼

Notes

1. Kenneth T. Jackson, *Crabgrass Frontier: The Suburbanization of the United States* (New York: Oxford University Press, 1985), 224, 7.
2. Paul Boyer, *Urban Masses and Moral Order in America, 1820–1920* (Cambridge: Harvard University Press, 1978), vii, 1–165; Robert H. Bremner, *From the Depths: The Discovery of Poverty in the United States* (New York: New York University Press, 1956), 3–15.
3. Roy Lubove, *The Progressives and the Slums: Tenement House Reform in New York City, 1890–1917* (Westport, Conn.: Greenwood Press, 1974), 25–28, 49–149.
4. *Ibid.*, 33–39; Lawrence M. Friedman, *Government and Slum Housing: A Century of Frustration* (Chicago: Rand McNally, 1968), 73–94.
5. Lubove, *Progressives and the Slums*, 144–49; Friedman, *Government and Slum Housing*, 86–89.
6. Two of the older standard accounts of American reform ignore the Progressive housing movement (see Richard Hofstadter, *The Age of Reform: From Bryan to F.D.R.* [New York: Vintage, 1955]; Eric F. Goldman, *Rendezvous with Destiny: A History of Modern American Reform*, rev. ed. [New York: Vintage, 1956]).
7. Lubove, *Progressives and the Slums*, 178.
8. Hofstadter, *Age of Reform*, 244–56; Gabriel Kolko, *The Triumph of Conservatism: A Reinterpretation of American History, 1900–1916* (Chicago: Quadrangle, 1967), 195; William H. Wilson, *The City Beautiful Movement* (Baltimore: Johns Hopkins University Press, 1989), 41, 78, 99–253.

9. Sidney Fine, *Laissez Faire and the General-Welfare State: A Study of Conflict in American Thought, 1865-1901* (Ann Arbor: University of Michigan Press, 1956); Kolko, *Triumph of Conservatism*, 190-305.
10. Hofstadter, *Age of Reform*, 186-98; Friedman, *Government and Slum Housing*, 39-44.
11. Bremner, *From the Depths*, 16-17. See also Boyer, *Urban Masses*, 90, 146.
12. Bremner, *From the Depths*, 123-39; Boyer, *Urban Masses*, 90, 154-55; M. Christine Boyer, *Dreaming the Rational City: The Myth of American City Planning* (Cambridge: MIT Press, 1983), 14-28.
13. Friedman, *Government and Slum Housing*, 20-21.
14. Lubove, *Progressives and the Slums*, 66-67, 174-75; Boyer, *Urban Masses*, 189-251; Bremner, *From the Depths*, 212-59.
15. C. Van Woodward, *The Strange Career of Jim Crow*, 2d rev. ed. (New York: Oxford University Press, 1966), 88-93; August Meier and Elliott M. Rudwick, *From Plantation to Ghetto: An Interpretive History of American Negroes* (New York: Hill & Wang, 1966), 164, 169-71, 185-86; John Higham, *Strangers in the Land: Patterns of American Nativism, 1860-1925* (New York: Atheneum, 1973), 131-57.
16. Lubove, *Progressives and the Slums*, 7, 31, 94-95.
17. Jackson, *Crabgrass Frontier*, 116-17.
18. Massachusetts Rapid Transit Commission, *Report of the Rapid Transit Commission to the Massachusetts Legislature* (Boston, 1892), 15-16.
19. Adna Ferrin Webber, *The Growth of Cities in the Nineteenth Century: A Study in Statistics* (Ithaca: Cornell University Press, 1967), 458.
20. Jackson, *Crabgrass Frontier*, 174-75; James J. Flink, *America Adopts the Automobile, 1895-1910* (Cambridge: MIT Press, 1900), 108-10; Lubove, *Progressives and the Slums*, 221-29.
21. Lubove, *Progressives and the Slums*, 176-77; Roy Lubove, *Community Planning in the 1920's: The Contribution of the Regional Planning Association of America* (Pittsburgh: University of Pittsburgh Press, 1963), 5-15; Boyer, *Dreaming the Rational City*, 103-4. It should be noted that Lawrence Veiller rejected home ownership as a necessary goal for the poor (*ibid.*, 100). Some even found the three-family wooden three-decker little better than a tenement. Harvard president Charles Eliot condemned the inexpensive buildings for housing "a class of nomads" and for having "a depressing effect on property values, and whenever it appears it sends down the price of real estate." (Quoted in *ibid.*, 104).
22. Jacob A. Riis, *How the Other Half Lives: Studies among the Tenements of New York* (New York: Hill & Wang, 1957), 210.
23. Friedman, *Government and Slum Housing*, 47-48; Lubove, *Progressives and the Slums*, 180-81.
24. Lubove, *Progressives and the Slums*, 38-39; Friedman, *Government and Slum Housing*, 77-86.
25. Seymour I. Toll, *Zoned American* (New York: Grossman, 1969), 74-187.
26. *Ibid.*, 147, 151-52, 171, 199, 210; Boyer, *Dreaming the Rational City*, 171.
27. *Ibid.*, 187-98.
28. Roy Lubove, "Homes and 'A Few Well Placed Fruit Trees': An Object Lesson in Federal Housing," *Social Research* 27 (Winter 1960): 469-86; Christian Topalov, "Scientific Urban Planning and the Ordering of Daily Life: The First 'War Housing' Experiment in the United States, 1917-1919," *Journal of Urban History* 17, no. 1 (November 1990): 14-45.
29. Boyer, *Dreaming the Rational City*, 148-153; Toll, *Zoned American*, 201.
30. Toll, *Zoned American*, 201.

31. Ibid., 188–93.
32. *Village of Euclid, Ohio v. Ambler Realty Co.* 272 U.S. 365 at 390, 394.
33. Toll, *Zoned American*, 213–53; Timothy Alan Fluck, "Euclid v. Ambler: A Retrospective," *Journal of the American Planning Association* 52 (Summer 1986): 326–37.
34. Boyer, *Dreaming the Rational City*, 153–57.
35. Jackson, *Crabgrass Frontier*, 193–95.
36. Ibid., 195–203.
37. Ibid., 203–06.
38. Charles Abrams quoted in Mark I. Gelfand, *A Nation of Cities: The Federal Government and Urban America, 1933–1965* (New York: Oxford University Press, 1975), 220.
39. Jackson, *Crabgrass Frontier*, 206–18; Gelfand, *Nation of Cities*, 216–22.
40. Nathaniel S. Keith, *Politics and the Housing Crisis since 1930* (New York: Universe Books, 1973), 17–19; Lubove, *Community Planning*, 17–22.
41. Eugenie Ladner Birch, "Woman-Made America: The Case of Early Public Housing Policy," *Journal of the American Institute of Planners* 44 (1978): 130–36. On the RPAA see Lubove, *Community Planning*.
42. Birch, "Woman-Made America," 138–41; Gelfand, *Nation of Cities*, 24–25, 59–63; Keith, *Politics and the Housing Crisis*, 27–36.
43. Friedman, *Government and Slum Housing*, 109.
44. Ibid., 99–100, 106–13.
45. Birch, "Woman-Made America," 138, 141.
46. Quoted in Bremner, *From the Depths*, 47–48.
47. Friedman, *Government and Slum Housing*, 113.
48. Irving Welfeld, "American Housing Policy: Perverse Programs by Prudent People," *Public Interest*, no. 48 (Summer 1977): 134; R. Allen Hays, *The Federal Government and Urban Housing: Ideology and Change in Public Policy* (Albany: State University of New York Press, 1985), 96.
49. Ibid., 96–98. Before World War II, Edith Wood, Catherine Bauer, and other housing advocates labored mightily with some success to produce decent public housing in spite of the limitations of the Wagner Act (see Birch, "Woman-Made America," 141).
50. Jackson, *Crabgrass Frontier*, 224–27; Hays, *Federal Government and Urban Housing*, 131.
51. Jackson, *Crabgrass Frontier*, 204–06, 231–45.
52. Ibid., 206; Jean Gottmann, *Megalopolis: The Urbanized Northeastern Seaboard of the United States* (Cambridge: MIT Press, 1961), 417–20.
53. Hays, *Federal Government and Urban Housing*, 91–92; Friedman, *Government and Slum Housing*, 109–110.
54. Keith, *Politics and the Housing Crisis*, 58–100; Gelfand, *Nation of Cities*, 144–56.
55. Friedman, *Government and Slum Housing*, 148–50; Gelfand, *Nation of Cities*, 109–110, 145–56.
56. Friedman, *Government and Slum Housing*, 148–72.
57. Jackson, *Crabgrass Frontier*, 224.
58. Birch, "Woman-Made America," 141–42.
59. Friedman, *Government and Slum Housing*, 109.

60. Hays, *Federal Government and Urban Housing*, 181–86. For a chilling case study of displacement at its worst, see Robert A. Caro, *The Power Broker: Robert Moses and the Fall of New York* (New York: Knopf, 1974), 966–87.
61. Quoted in Birch, "Woman-Made America," 142.
62. Jane Jacobs, *The Death and Life of Great American Cities* (New York: Random House, 1961), 4.
63. Keith, *Politics and the Housing Crisis*, 110–45; Gelfand, *Nation of Cities*, 157–97, 308–47.
64. Keith, *Politics and the Housing Crisis*, 151–73; Gelfand, *Nation of Cities*, 348–89.
65. Hays, *Federal Government and Urban Housing*, 87–89, 104; Keith, *Politics and the Housing Crisis*, 186–93.
66. Hays, *Federal Government and Urban Housing*, 133–36, 151.
67. Jackson, *Crabgrass Frontier*, 214–15.
68. Hays, *Federal Government and Urban Housing*, 112–20, 130, 141–43.
69. *Ibid.*, 150–58.
70. Michael H. Lang, *Homelessness amid Affluence: Structure and Paradox in the American Political Economy* (New York: Praeger, 1989), 12–19.
71. Quoted in Gelfand, *Nation of Cities*, 361.

Streets Are for Nobody: Caroline

Just sixty; worked most of her adult life; now on pension; waiting for elderly housing.

I went to State Teacher's College when I got a commission in the air force during Korea. I spent eight years in the air force. I was offered a job at Lockheed Aircraft in Burbank doing the same thing I did in the air force at a tremendous salary, which I took. I worked there for seven and a half years and came back to Boston because my sister, at that time, had been remarried and she needed me because of problems that she was having. I worked eight years for an insurance company as the assistant treasurer and full-charge bookkeeper for a subsidiary company.

My sister became ill. They had moved to San Francisco with their daughter. She had suffered two heart attacks and she asked me to come out there because she could not control her daughter who was having an emotional problem. I then left my job and went out to San Francisco. During the course of the first year, I worked temporary doing accounting work because I had to be home with her. I had the daughter go to the University of California at Davis, which I paid for. She wanted to be a librarian.

My sister then suffered diabetes. She started losing her eyesight, her kidneys started deteriorating. I kept working as much as I could temporary. [Caroline's sister died and she was hospitalized for depression.] It's been very difficult for me because of heavy medications I take both for physical and mental reasons to have [the] concise thinking that one needs in the accounting work.

My mother died when I was twelve and my father when I was ten. And my sister raised me. My sister was both my mother, my sister, and my best friend. That's why the doctor said that it was too much of an emotional loss, it was my last tie to the family.

[People on fixed income have difficulty getting apartments.]

I went to a Realtor on Marlborough Street who I knew slightly and I explained my situation. I'm on a fixed income. He said, "Caroline, you've got good references and I know you. I wouldn't hesitate to place you. But how can I place you in an apartment building where the landlord next year will raise the rent?" They see you on fixed income, they don't want you because they're not going to get any more money out of you. Plus the fact that if you've been homeless for a period of time, they don't want to touch you.

Interviewed by Melissa Shook, July 7, 1988, Boston. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

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Everybody [else] lives within two or three paychecks of poverty 'cause everybody spends everything they earn. God knows I did when I earned top dollar. I spent it on trips, cars, and my family, my niece particularly.

I think the main thing of being homeless is the loss of esteem, the loss of contributing to people, to the world, doing something constructive. You're treated like a piece of material that has to move to this line, to that line. I believe in rules and regulations. I spent eight years in the air force and I enjoyed rules and regulations. I know with a large group you have to do that. But I think when you're homeless, you can't do it. Because you have no identity. You're just, "You over here. You get up. You can eat now."

And it's sad to lay there at night. Last week there was a woman came, was a nurse, raised children. Unfortunately, she's on a pension, like myself, can't afford a place and she told me, "What am I going to do?" I said, "You'll have to ride it out. And maybe they'll get you into a boardinghouse or maybe your name will come up on a [subsidized housing] list or maybe you'll win Megabucks." And she went crazy the other night. She just couldn't control herself any more. Now, she's at the mental hospital and God knows if she'll be able to snap back.

I've seen them go out of the lobby and two or three cops holding them, taking them out. They bring them to Lindemann Center, dose them up, and they come back like little automatons.

I think the saddest part is to sit and watch someone you know and you like, maybe you don't even have to like them, but to see a person deteriorate right in front of you and you don't have the sources to stop it. I've kind of pulled back because I can't watch people do that any longer.

Half the people won't talk to each other out in public. I had a friend brought over another from the shelter to sit at her table. She [the friend] had to pay and leave because the woman's behavior was so bizarre, everybody in the restaurant was looking at her. So that's why there are very few friendships in the shelter; it's because you don't want to be hurt by them in public, plus you don't want to be hurt yourself by seeing people you like go down the tubes. You can take a lot, but that I think is the one thing you can't take. It's terrible.

I myself have to go to the clinic three mornings a week for treatment. Afterwards, I usually try and get to a movie if I feel that I'm sliding in a depression. Or I go down by the water. I love to look at the water. Or I go to the library and read. Or I go to the museum, look around. I try to keep myself doing normal things, what I would do if I was on a normal retirement and had time to kill. I always try to keep interested in current affairs. I read a great deal. Reading has been my salvation. It's the only thing that has kept me sane. ♡

Housing the Homeless Through Expanding Access to Existing Housing Subsidies

Barbara Sard

The premise of this article is that homelessness in America today is essentially a product of the lack of affordable housing for very low-income people. The article outlines this central income/housing gap analysis as the factual predicate of the goal to alleviate homelessness through securing subsidized housing resources for the homeless and imminently homeless. It explains why, based on the nature and number of annually available housing subsidies, expanding access to existing housing subsidies is a valuable, workable, short-term, at least partial solution to the immediate crisis of lack of affordable housing, albeit one which does not negate the acknowledged necessity of increasing the supply of such subsidies. It suggests six strategies legal advocates may pursue to expand access for the homeless to the existing housing subsidy resources in their community. Finally, questions are raised about the value of this approach, in contrast to a focus solely on increasing the overall supply of income or housing subsidies, for which space permits only limited and tentative answers.

Homelessness in America today is essentially a product of the lack of affordable housing for very low-income people. While “macro” solutions in the form of increased incomes, an increased number of subsidies for housing, and an increased supply of lower-cost housing are vital, they require years of political and legislative effort. If only macro solutions will solve the problem, what are lawyers representing homeless clients today to do? Is there a legal strategy available to assist these clients to solve their central problem, the lack of a place to live that they can afford? The answer is yes, through expanding access to existing housing subsidies.¹

Why is Expanding Access a Worthwhile Approach?

The current crisis of homelessness in our society is primarily the result of the increasing gap between household income and housing costs. While individual dysfunctions may help determine which families or individuals are most vulnerable to the shortfall in the supply of housing that the poor can afford, the predominant

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cause of the worst homelessness epidemic since the Great Depression is increasing poverty in the face of a decreasing supply of low-cost housing.²

What the confluence of these forces means, in practical terms, with regard to the ability of the private housing market to meet housing needs, is that either there is too little low-cost housing in a community for those who need it or, particularly in many of the country's major urban areas, which experienced extreme inflation in housing costs in the 1980s, there is virtually no private market housing within the economic reach of the homeless. Nor can the private housing market, without substantial government subsidies, increase the supply of housing that the homeless or imminently homeless can afford.

Consequently, the solution to the income/housing gap lies in closing the gap from either, or both, directions: by increasing their income so the homeless can afford whatever housing there is, and/or by increasing the supply of housing subsidies. Even in areas of the country where the housing stock is such that increased incomes or housing purchasing power would substantially alleviate the problem, it is extremely difficult to muster the political will to expand and increase public assistance income maintenance programs, which could provide such income. This is even more true in communities where housing costs have escalated. The same can be said for the political barriers that exist to the creation of the kind of job training plus public employment (and child care) programs which are necessary if any substantial number of the homeless are to increase their incomes through employment rather than income transfers.

Thus, whether by choice³ or necessity, the primary solution to the income/housing gap is to increase the amount of subsidized housing⁴ available to the homeless and imminently homeless. One obvious way to accomplish this goal is to legislate an increase in deep subsidy housing programs and require all or some significant portion of the increased resources to go to the homeless and imminently homeless. In light of the enormous shortfall between housing needs and housing supply, a strategy directed at "more" is certainly vital. Without it, we will not end the national disgrace of homelessness.

However, whether it is possible to generate the political will to increase the supply of housing is perhaps as doubtful as the possibility of creating the political will to substantially increase the incomes of the poor. While the struggle to increase the total supply of housing continues in these tight fiscal times, to assist the currently homeless, it is imperative to look to whether the existing supply of subsidized housing is being fully utilized or is going to those legally entitled to, and most in need of, such subsidies. There are additional strategies available to homeless people and their advocates to increase the proportion of the existing supply of subsidized housing which goes to the homeless and imminently homeless. As these strategies can result in virtually immediate housing solutions for at least some of the homeless, they can be used by lawyers and others working with individual homeless clients and client groups to "solve" their clients' problems. I outline six strategies to maximize access of the homeless and imminently homeless to existing housing subsidies and briefly review some of the questions they raise. While I draw heavily on my experience in Massachusetts, the strategies should be replicable elsewhere.

Subsidies Exist

Currently, there are three major kinds of deeply subsidized federal housing programs. "Walk-around" rental subsidies, usually known as Section 8 certificates or

vouchers, issued by public housing authorities (PHAs), can be used by the holder to rent a housing unit of acceptable quality. Public housing consists of housing units owned and usually managed by a PHA, in which the tenant's rent is limited to 30 percent of income. Privately owned, federally subsidized developments have "project-based" subsidies available to some or all of the tenants who move into those developments. Some states also fund deep subsidy housing programs, which may be similar in program design to the federal programs.

As of 1988, 2.3 million households received Section 8 subsidies, most of which were walk-around certificates or vouchers. Also as of 1988, there were 1.4 million public housing units managed by PHAs. Of the privately owned housing constructed or substantially rehabilitated with federal funds, in addition to those with Section 8 subsidies included above, there are several hundred thousand deeply subsidized units.

Besides the relatively small number of additional new subsidies or subsidized units for which funds have been appropriated by Congress each year, a not insignificant number of units and subsidies annually become available as current tenants leave or become ineligible for continued subsidy. No national data appear to be maintained on the number and type of such "turnover" subsidies. If the Massachusetts experience is typical, however, approximately 10 percent of Section 8s turn over and are available for reissuance each year. The turnover rate for public housing in Massachusetts appears to be somewhat less: state officials have estimated that approximately 5 percent of public housing units turn over each year, although the rate is much higher at the violence-plagued inner-city projects in Boston. Extrapolating from these rates, it is likely that roughly 330,000 such units are available for reassignment each year.

While 330,000 deep subsidies, even were they all targeted annually to the homeless, are inadequate to meet the need (and we must not forget that the "need" extends beyond those who are already homeless or at immediate risk of becoming homeless), it is surely not an insignificant figure. Ironically, it is more than sufficient to house the number of homeless estimated by the Reagan administration in 1983.⁵

Potential Strategies to Maximize Access

My premise is that, currently, a relatively small proportion of the existing deeply subsidized housing resources which turn over each year are reissued to the homeless, or even the imminently homeless.⁶ The reasons for this are several. First, households with a fairly broad range of incomes are eligible for federally subsidized housing programs. Families with incomes up to 50 percent of the area median income are eligible for all deeply subsidized federal housing assistance programs. Families with even higher incomes are eligible. While many families nearer the upper end of these income limits undoubtedly have housing needs, they are unlikely to be homeless without housing assistance. Second, Congress has defined the categories of applicants who must receive preference for federal housing resources far more broadly than the currently or imminently homeless or displaced, as applicants living in substandard housing or paying more than 50 percent of their income for housing costs also receive preference. Finally, many homeless applicants are excluded from participation in subsidized housing programs as a result of the policies and practices described below.

How existing deeply subsidized housing resources are distributed may usefully be categorized into six problem areas. Successful efforts toward challenge or reform in

the following areas should result in a substantial increase in the resources allocated to those whose need is the greatest:

1. The failure of subsidized housing owners and PHAs to utilize available contracted federally funded subsidies
2. The violation of the federal preference rules by many PHAs and subsidized owners
3. The failure of most public housing authorities and subsidized owners to give top priority to the homeless
4. The administrative maze through which subsidized housing resources are delivered, requiring literally hundreds of applications to be filed in order to maximize the opportunity for a homeless applicant to obtain available resources
5. Procedural barriers erected by the housing authorities and subsidized housing owners, which have a particularly harsh impact on the homeless
6. Discrimination by many public housing authorities and subsidized housing owners against disabled and handicapped applicants who are not mobility impaired.

Failure to Utilize Federally Funded Subsidies

When Section 8 new construction and substantial rehabilitation projects were funded by HUD in the 1970s, HUD entered into contracts with the owners to subsidize, through the Section 8 program, the rent of families in a specified number of units, so that each such family would have to pay only the percentage of family income for rent required under the Section 8 program. Rather than utilizing all these subsidies, owners of an increasing number of projects have been renting what should have been subsidized units at market rates.

Because of standing barriers erected by some federal courts to challenges to such underutilization by applicants, it has been difficult through litigation to remedy the problem and make these funded subsidies available to needy families. In the Cranston-Gonzalez National Affordable Housing Act, Congress has effectively reversed the prior appellate decision, as well as making clear that owners are legally obligated to use their full contract authority to rent to income-eligible families. Consequently, litigation to enforce the use of all available subsidies should now be possible. At least 70 percent of the subsidized units that become available under this law must go to federal preference holders, including the homeless.

While the Cranston-Gonzalez amendments have, on the whole, made it far more straightforward to achieve full utilization of deep subsidies in privately owned developments, the mere enactment of this law is not likely to alter the predilection of owners to rent to more affluent tenants. Thus, enforcement may well be necessary to realize the increased availability of subsidies that the law requires. Rather than the highly laborious work required to determine whether there are unutilized subsidies in any particular development,⁷ it may be possible to induce, or require, a state agency, if not HUD, to undertake such enforcement work.

Public housing authorities administering Section 8 existing and Section 8 voucher programs may also have contracted and funded Section 8 subsidies available, which they are unlawfully failing to distribute. For the last several years, the Worcester, Massachusetts, Housing Authority failed to allocate over 340 Section 8 certificates and vouchers, approximately 30 percent of its total portfolio. In mid-1990, the Chelsea, Massachusetts, Housing Authority decided to stop issuing its available Section 8 subsidies. Neither of these housing authorities turned these funded resources

back to HUD for reallocation to PHAs willing to use them, so available federal funds for deep subsidies simply went unutilized. When legal services attorneys placed the HUD regional office formally on notice of the blatant failure of these PHAs to comply with federal policy, and, at least in Chelsea, the probable racially discriminatory motivation for such failure, HUD did intervene, without litigation, and require the PHAs to issue and lease, up to available subsidies, to applicants selected in accordance with federal law.

Violation of the Federal Preference Rules

Traditionally, subsidized housing resources were distributed on a first come, first served basis through a chronological waiting list maintained by each housing authority. In recognition of the enormous shortage of housing resources in relation to need, particularly after the drastic cutbacks in federal funding for low-income housing that began in the early eighties, Congress directed that certain categories of applicant families be given preference over earlier ("standard") applicants not qualifying for preference in the various federal housing programs. In January 1988, HUD finally promulgated regulations to implement these federal preferences.

Under current law, federal preference is given to three categories of applicants: those occupying substandard housing (including the homeless), involuntarily displaced, or paying more than 50 percent of their income for rent. The substantial majority of federally subsidized housing resources must be distributed to applicants qualifying for one of these preferences. While PHAs and owners may use "local" preferences to rank all federal preference holders, all applicants qualifying under at least one of the federal preference categories must come before applicants who do not qualify for federal preference, with minor exceptions.

Because of the preferred status that proper implementation of the federal preference regulations gives to homeless applicants (at least those who meet the federal definition), it is potentially critical to homeless applicants' achieving relatively quick receipt of a housing subsidy that PHAs and subsidized owners grant federal preference to homeless applicants who are entitled to it and that they abide by the requirement that federal preference holders come before standard applicants.

The only data HUD appears to keep on PHA implementation of the federal preference regulations are in the individual management audits of particular housing authorities. It appears that HUD audits emphasize units or certificates wrongly issued, rather than checking cases of applicants who may have been wrongly denied.

Based on two years of experience of the Greater Boston Legal Services (GBLS) Homelessness Unit representing applicants for federal preference at a variety of PHAs and private federally subsidized owners in eastern Massachusetts, however, I believe that there may be widespread violation of the federal regulations. For example, in a medium-size housing authority right next to Boston, GBLS discovered that 41 percent of the Section 8 certificates awarded in the first eighteen months after the federal preference regulations went into effect went to non-federal preference holders, at a time when the PHA admitted that it had federal preference holders on its waiting list.

Such a violation of the fundamental rule of federal preference holders first can occur for a variety of reasons, beyond the straightforward legal violation that appears to have occurred at this PHA. At many PHAs in Massachusetts, we have found that the PHAs' federal preference "system" does not on its face comply with

federal law, usually either because it omits any mention of groups mandated by the federal regulations as federal preference holders and/or because it explicitly places some groups, deemed to have "local" preference but who do not fit into any of the federal preference categories, in a ranking above federal preference holders. We have also found PHAs which, in their application of their preference plans, deny federal preference status to applicants who come within the federal definitions.

Such practices not only result in applicants who are legally entitled to federal preference status being denied such status, and therefore probably subsidized housing as well, but also make it possible, depending on the number of federal preference holders on the waiting list in relation to the number of available resources, for applicants without federal preference to obtain more of the available subsidies. In addition, if a PHA closes its waiting list for Section 8 applicants when its waiting list contains any standard applicants or when it has a ranked preference system and its list contains applicants with less than first preference, it is likely that the PHA is unlawfully denying the right of an applicant claiming federal preference status to be placed on the waiting list. As a consequence of such unlawful closing, applicants entitled to federal preference status are substantially delayed in their receipt of housing assistance, or totally denied such right.

By aggressive representation of applicants for subsidized housing resources, it should be possible to remedy these violations and enforce homeless applicants' rights as federal preference holders. However, it would certainly be more efficient if HUD could be made to take its role as grantor of federal funds more seriously, in light of the fact that actions may otherwise have to be brought against a very large number of PHAs (although class or group defendant actions could be possible). More aggressive congressional oversight could induce such action on HUD's part. It could also be a worthwhile strategy to sue HUD for its failure to properly implement the federal housing laws, including the fair housing laws, as violation of the federal preference rules is likely to have a racially discriminatory effect.

Failure to Give Top Priority to the Homeless

Public housing agencies and private subsidized owners administering federally subsidized housing programs subject to the federal preference regulations have the authority, under the HUD regulations, to rank the federal preference categories, or even subgroups within the categories. Where subsidized housing resources are insufficient to serve all applicants entitled to federal preference within a reasonable period of time, homeless applicants would benefit substantially if homelessness were to be ranked as the top preference category.⁸ In addition, public housing authorities could require that the homeless receive all or a substantial portion of the 30 percent of units with project-based assistance for which they have discretion to set local, nonfederal preference for admission.

HUD does not keep any centralized records, nor has it issued any reports, of what preference systems have been adopted by PHAs, so it is impossible to say with any precision what percentage of PHAs or owners administering federal housing resources accord top preference to the homeless within a ranked preference system. If the Massachusetts experience is typical, however, most PHAs, at least the smaller ones, and most private owners of federally subsidized units do not rank the federal preferences at all. Of those which do have a ranked system, the homeless are ranked first in few cases.

There are basically two approaches to accomplishing top ranking of homeless applicants for federal housing resources in particular areas: persuasion or mandate. Persuasion may be grounded on public policy-relative need arguments alone,⁹ or enhanced by a fiscal "incentive," such as occurs when the costs of emergency shelter will be reduced by targeting housing resources at the families who would otherwise be sheltered at enormous state expense. A mandate can be achieved through administrative rule making by a supervisory state housing agency, legislation,¹⁰ or court order. Politics will probably dictate whether administrative or legislative advocacy is likely to be fruitful in a particular state. While no court has, to my knowledge, yet issued such an order, it is within a court's equitable power to do so where executive branch liability for homelessness of a particular group has been found, and where there may be no, or insufficient, appropriated funds available to fashion a remedy.

Balkanized Administration of Programs

When a person in the United States wishes to apply for Social Security benefits, he or she goes to the Social Security Administration office that serves the local area. The benefits the person is eligible to receive are the same regardless of where in the U.S.A. the person lives, and the time it takes to receive benefits after application is unlikely to vary according to where the person applies. The same situation occurs for persons wishing to apply for unemployment compensation or public assistance benefits, although the benefits vary in each state.

In contrast to virtually all other major government benefit programs for individuals, however, anyone wishing to apply for subsidized housing has to make literally hundreds of applications in any particular state in order to maximize the chances of receiving benefits. This can be true even in a state where the only subsidized housing programs are federally funded.

Such balkanized distribution of a basic resource is a product of the localized system of funding conduits established by Congress for federal housing dollars. In the first thirty years of federal housing programs, funding essentially went into public housing programs, through contracts with public housing authorities established pursuant to state law. Generally, the jurisdiction of a PHA follows city or town lines, although regional or even statewide PHAs are possible. While we have only fifty states, approximately 2,000 PHAs administer a federal Section 8 program. In some states, an applicant must file separate applications at literally hundreds of PHAs to maximize his or her chance of receiving a walk-around Section 8 subsidy, even though such subsidies can now be used anywhere in the state (and in some contiguous areas of neighboring states).

Complicating matters further, PHAs frequently require a separate application to be filed for their public housing and Section 8 project-based programs, in addition to the application for walk-around Section 8 certificates and vouchers. Then, in addition to the tens or hundreds of PHAs at which one might wish to submit one or several applications, to receive a project-based subsidized unit at one of the potentially hundreds of privately owned and federally or state subsidized developments in an area, a separate application must be made to *each* project.

Not only are there hundreds of PHAs or private developments to which one should apply to maximize one's chances of receiving a housing subsidy, but each PHA or private developer is free, under federal law, to adopt its own system for ranking the federal preferences. State-funded resources may be distributed under

rules different from the federal preferences. While at least the PHA plans and rules are technically publicly available,¹¹ there is no one place to get them. No government agency gathers them all, nor is any government agency required to collect turnover and waiting list information.

Consequently, it is impossible for a homeless applicant desperate for housing to act like the proverbial rational person, choosing to apply at those agencies/developments where they are likely to have the best chance of getting housing in light of the fit between their circumstances and the applicable tenant selection rules and the relative availability of new or turnover resources in the bedroom size they need.

While major urban centers may have years-long waiting lists even for federal preference holders, the experience in Massachusetts has been that PHAs in small communities frequently have relatively few federal preference holders on their waiting lists. A homeless applicant who is legally entitled to preference may then be able to receive a housing subsidy fairly quickly from an outlying community in the suburban ring or even in a distant rural area. Even if the family does not wish to move to the grantee community, a Section 8 walk-around subsidy can be used to rent housing in the urban area of origin, or any other community in the state to which the person wishes to move.

While federal law permits this balkanized "system" of distributing federal housing resources, it does not require it, at least in its current extreme form. Just as states could require all PHAs and private owners with federally subsidized resources to comply with a state-ordered system for ranking federal preference holders, states could also require PHAs and owners to submit information about likely availability of units to a central or regional clearinghouse, and litigation could provoke them to mandate such reporting. States could also reduce the barriers created by balkanized administration by requiring PHAs and private subsidized owners to accept applications by mail, and to use the same application form, which could be photocopied and sent to the long list of distributors of subsidized housing resources.

While such state-level strategies only tinker with the federally created balkanized system, which can best be altered by changing federal law, implementation of clearinghouses and streamlined application processes should help increase the consciousness of the sharp inconsistency between the nature of current housing subsidy programs, in which approximately half the resources are portable income subsidies, and the outdated localized manner in which housing resources are now distributed, and of the need for change.

Procedural Barriers

Achieving access to existing subsidized housing resources requires surmounting a number of procedural barriers, which create particular difficulty for the homeless. For example, PHAs frequently refuse to take any applications for their Section 8 programs, even from federal preference holders, on the grounds that their lists are "closed." People who do manage to get their names on the waiting list are frequently "purged," for failure to respond to a letter sent to an address they are no longer at, even though the PHA had no resource to offer the person at the time the letter was sent, but was simply "updating" its list. For those who do make it through to the eligibility determination process, a seemingly endless stream of verification require-

ments, often for pieces of paper a homeless person cannot possibly obtain,¹² creates a literal “paper chase” that inevitably winnows down the number of applicants able to complete the course. Finally, because the notices and appeal procedures used by many PHAs and private subsidized owners lack the basic rudiments of due process, applicants are frequently unable to effectively utilize the appeal process to vindicate their right to receive subsidized housing resources.

None of these procedural barriers is required by federal law, although some, such as the purging of the lists, appear to be encouraged by HUD. Some may be motivated in part by concerns of administrative efficiency. None was designed explicitly to exclude the homeless.¹³ However, in each of these respects, PHAs are unfortunately following in the steps of other bureaucracies seeking to limit the number of applicants found eligible, without publicly admitting that they are narrowing the eligibility rules, with the effect of making the perceived need for subsidized housing substantially less than the reality.

PHAs may also, by creating such procedural hurdles, be purposely trying to exclude those least able to negotiate the obstacle course: the least literate, the least articulate, the least mobile (to get around to the required verification sources), and those without stable addresses. These are likely to be the poorest of the applicants, disproportionately language and/or racial minorities, and the handicapped. Such exclusionary tactics may be motivated simply by localism — a desire not to distribute scarce housing resources to people not seen as “theirs” — and/or by racial or class prejudice. Whatever the motivation, advocates for the housing needy in general, as well as the homeless, should expose such policies as having no proper place in government-funded housing programs and work to eliminate them.

All these procedural barriers are subject to legal challenge or could be altered by state-level rule making or legislation, as briefly suggested above, as well as, of course, by changes in federal regulations or statute. Such changes would benefit not only homeless applicants, but all applicants for public and subsidized housing resources. Why have few such challenges been brought? Probably because subsidized housing admissions issues have not been a primary focus of legal effort since initial, basic reforms were accomplished in the late sixties and early seventies, after federally funded legal services were first available, such as waiting lists, proscribing arbitrary exclusions of classes of potentially eligible applicants, and rudimentary notice and hearing requirements.

From the perspective of clients who are desperate for housing, however, overcoming these procedural barriers, particularly after the implementation of the federal preferences, is often the means to solving the clients’ most critical problem. Such advocacy can not only help numerous individual clients as well as applicants overall, but can also eliminate structural barriers to homeless applicants’ being able to benefit equally from publicly funded housing programs.

Discrimination

A significant proportion of the homeless, particularly of people without minor children, meet the federal definitions of “disabled” or handicapped.” As a result, they meet not only the basic categorical eligibility requirement federal law has imposed on single applicants for housing,¹⁴ but are eligible for special elderly/handicapped housing resources, in addition to family housing.

Some local housing authorities and private subsidized owners have unlawfully restricted elderly/handicapped housing to the elderly and the mobility-impaired handicapped, who need the alleged special amenities of such housing, prohibiting access to other handicapped and disabled persons. In some areas these unlawful practices have resulted in subsidized housing units remaining vacant because the aged applicants — those actually sixty-two and over — may not wish to go into the available units because of the neighborhood in which they are located. In addition, because relatively few such actually elderly applicants are entitled to federal preference, compared, for example, with the actually homeless or precariously housed disabled or handicapped, even if there were not units standing vacant, eliminating such discrimination should result in relatively rapid offers of turnover housing resources to applicants with federal preference status.¹⁵

In addition to removing such blanket exclusions of the non-mobility impaired disabled and handicapped from housing for which federal law makes them eligible, it will also be necessary, to open up such housing resources and all other family housing resources to many of the now homeless, to eliminate tenant suitability standards, which have a discriminatory impact on the handicapped, particularly the mentally handicapped. A landmark case on this issue was recently won.¹⁶ Although the judgment technically applies only to the local PHA, HUD has written instructions to all PHAs to follow the court's ruling in that case, as HUD has agreed that the court's decision is required by the Fair Housing Act Amendments, which HUD is bound to uphold.

Even with such instructions, however, if past experience is a guide, the instructions will not automatically be complied with. As HUD is notorious for failing to supervise PHAs, and particularly private owners, actual enforcement will require state- and local-level vigilance. In addition, other common PHA or private subsidized owner systematic exclusions of applicants on suitability grounds, such as denials for prior records of "bad" tenancies, despite proof of subsequent rehabilitation from the substance abuse that caused the prior bad acts of failure to pay rent, damage to the apartment, and so on, may be challengeable on handicap discrimination grounds. This is a fertile area for creative legal work.

Long-term Questions about Subsidy Eligibility

In any single year, and perhaps over an even longer time frame, advocacy targeted at who gets available subsidized housing resources is admittedly a strategy that does not get beyond a zero-sum game, except in the instances when available subsidies are not being used. Therefore, focusing on access and eligibility issues on behalf of the homeless, particularly preference rules,¹⁷ is potentially divisive of the broader constituency for increasing the supply of housing benefits and affordable housing programs.

Perhaps it is a sufficient justification that obtaining housing subsidies for otherwise homeless clients is a critical service to our arguably most needy clients. But when housing lawyer colleagues challenge this work as "merely rearranging the deck chairs on the *Titanic*," it would be preferable to have a better response than that all the applicants are not equally likely to drown.¹⁸

While there is not yet evidence to prove the proposition in the housing context, recent experience in other social welfare programs suggests that a potentially

expansive dynamic can result from making visible the "holes in the safety net." For example, concerted publicity about the cutoff of SSI and Social Security Disability benefits by the Reagan administration's severe review policy finally prompted not only judicial, but also congressional sanction to ensure that the disabled continued to receive benefits. In the mid-1980s, Congress also redressed a few of the eligibility restrictions it had imposed on the AFDC and food stamp programs, after hearing evidence that the harm inflicted was more severe than intended.

Similarly, one hoped-for result of struggling to expand subsidized housing priority for the homeless, in the rules both as written and as applied, is that increasing the number of applicants acknowledged to be entitled to preference will make the need even more visible, with a consequent increase in resources to respond to the need. True, homelessness is already the most visible part of the housing crisis. But many policymakers, as well as members of the public, nonetheless believe that the homeless are without housing because they are somehow not "housing ready" or don't want housing. Such detractors from the fundamental claim to housing should be undercut by cold proof of the numbers of applicants found eligible and entitled to priority status for subsidized housing whose needs cannot be met.

In addition, to the extent that housing authorities, legislators, and/or better-off applicants on the waiting lists object to the homeless being served "instead of" others, the challenge is to enlist the energy of these potentially more politically influential groups in the struggle to expand the supply of resources. Such hoped-for alliances may require that new resources be targeted to broader eligibility groups than the already homeless. But if the pot can truly be expanded more than homeless advocates could accomplish on their own, such an alliance is of general benefit.

The second major question raised by pursuing strategies to increase access to public and subsidized housing is whether increased centralization and standardization of programs and rules is really going to help low-income applicants in general, and homeless applicants in particular, over the long run. Advocacy pressure toward both centralization of formerly locally administered programs, and increased specification of eligibility rules and procedures, has been a key element of the welfare rights strategy for the last twenty-five years. While some proponents of progressive welfare programs have criticized these strategies for rigidifying welfare decision making,¹⁹ and it is certainly true that rules can be as exclusionary as unfettered discretion, on balance it appears that the politically disfavored are generally best off when programs for their benefit are administered at a level more distant from local prejudice, and when decisions must be made in accordance with rules subject to review.²⁰

Even if one accepts these general lessons drawn from the social welfare context, however, there is still a question whether the nature of housing programs requires or suggests an answer different from one in the welfare context. Arguably, the local nature of housing construction programs, with the inevitable issues of zoning, neighborhood mix, and the like, require as much locally based support as can be mustered. Even if that is true for construction programs, however, walk-around subsidies such as the federal Section 8 program are essentially income maintenance programs in a housing guise: they are income supplements earmarked for housing needs. Program beneficiaries are dispersed in the community, in whatever private units they can locate. No local support for building additional housing is necessary. Conse-

quently, whatever arguments for local administration of housing construction programs there may be do not appear to apply to programs that operate strictly as rent subsidies.²¹

While this discussion of the long-term implications of the strategies to increase access to existing subsidies and public/subsidized housing is necessarily preliminary, it suggests that a more thorough analysis of similar strategies used in other social welfare programs would be very helpful in the evolution of strategies to reform the administration of housing programs to meet the needs of our most low-income citizens. While such inquiry continues, however, and while efforts to increase housing resources go on, advocates should not overlook the substantial promise strategies such as those discussed in this article hold for creating real housing opportunities for homeless clients. ☺

Notes

1. The ideas presented here were generated and refined from the work of the Homelessness Unit of Greater Boston Legal Services in our representation of individual clients as well as the Massachusetts Coalition for the Homeless. Due to space constraints, most of the explanatory and supporting footnotes have been omitted from this article. A fully footnoted version, which is particularly useful for legal advocates, appears in the spring 1992 issue of the *Villanova Law Review*.
2. Useful readings on the economic causes of homelessness include P. Rossi, *Down and Out in America: The Origins of Homelessness* (Chicago: University of Chicago Press, 1989); K. Hopper and J. Hamburg, "The Making of America's Homeless: From Skid Row to New Poor, 1945-1984," in R. Bratt, C. Hartman, and A. Myerson, eds., *Critical Perspectives on Housing* (Philadelphia: Temple University Press, 1986); P. Leonard, C. Dolbeare, and E. Lazere, *A Place to Call Home: The Crisis in Housing the Poor* (Washington, D.C.: Center on Budget and Policy Priorities and Low Income Housing Information Service, 1989); C. Dolbeare, *Out of Reach: Why Everyday People Can't Find Affordable Housing* (Washington, D.C.: Low Income Housing Information Service, 1990); National Coalition for the Homeless, *The Closing Door: Economic Causes of Homelessness* (Washington, D.C., 1990).
3. Many housing advocates believe that it is preferable, as a policy matter, to close the income/housing gap from the housing side, through programs that not only subsidize but also control and reduce housing costs.
4. A "deep" subsidy is one that pays the difference between a percentage of tenant income — now 30 percent in the federal programs — and the full cost attributable to the housing unit. In contrast, a "shallow" subsidy is one that reduces housing costs, usually by reduction in the mortgage interest rate, or by syndication of tax credits, and/or by reduction in the cost of the land or buildings. Such shallow subsidies result in reduced rental prices in comparison with wholly private market housing, but they cannot, in light of the costs of building or purchasing and operating housing, bring costs within 30 percent, or even 50 percent, of a very poor family's income.
5. A 1984 HUD study numbered the homeless at 250,000-300,000. Most advocates for the homeless consider this an undercount. See Rossi, *Down and Out in America*, 37-38, and chap. 3. While any estimate of the number of homeless is necessarily inaccurate, given the difficulties of counting the homeless population, it is especially critical to remember that any such count is as of a single point in time, rather than the number of people who experience homelessness and therefore need housing over the course of a year. There are very few data on the duration of homelessness among various subpopulations of the homeless, although such data are critical for policy and planning purposes.

6. Unfortunately, there appears to be no data available on this question. There isn't even any federal data on the number of preference holders on PHA waiting lists. Conversation of Lisa M. Otero, my research assistant, with Jerry Benoit, HUD director of Rental Assistance, October 29, 1990. Based on available data in Massachusetts, I have estimated that only approximately 20 percent of the turnover deeply subsidized housing resources are issued to the homeless each year, including all state and federally funded housing resources, whether controlled by PHAs or by private owners.
7. Data on subsidy utilization should be available from HUD by means of a written request pursuant to the Federal Freedom of Information Act (FOIA). The most likely documents to contain the critical information for a subsidy utilization challenge are the Housing Assistance Payments (HAP) contract for each development and the owner's billing requests to HUD for the six or more months prior to the request.
8. It is probable that similar benefit would result even if homeless applicants were ranked after those involuntarily displaced, as the number of applicants displaced by natural forces, urban renewal activities, owners taking property off the rental market, or abuse are relatively small. In most jurisdictions, the largest group of preference applicants is likely to be those paying more than 50 percent of income for rent.
9. A PHA may also decide, based on its policy view and/or what it perceives as the particular needs in its area, to request that HUD approve an altered definition of "homeless." The Boston Housing Authority, for example, includes within its definition of homeless applicants who receive second preference and applicants who are doubled up in the home of another. HUD has recently approved this definition.
10. In a letter dated January 12, 1990, from Frank Keating, general counsel of HUD, to Alex Bledsoe, then deputy secretary of EOCD, Keating stated, "We find nothing in the United States Housing Act of 1937 or other Federal law which would constitute a legal impediment to PHAs following State-directed preferences for the homeless." The letter also says that whether a state housing agency, rather than a state legislature, could impose such state-required preference for the homeless on PHAs was a question of *state*, not federal law.
11. At least for PHAs, all tenant selection plans must be filed with the regional HUD field office, and therefore could be obtained through a Federal Freedom of Information Act request. The tenant selection policies and procedures used by PHAs in their public housing programs must be posted in each PHA office and made available to an applicant or tenant on request. 24 CFR §960.204(d)(2). Generally PHAs use the same federal preferences for their public housing and their Section 8 programs, although they do follow different tenant selection procedures in each program. Section 8 tenant selection preferences, policies, and procedures must be contained in a PHA's Administrative Plan for Section 8. 24 CFR §882.204(b)(3)(ii)(B). The HUD regional office may have the tenant selection plans used by private owners administering Section 8 project-based subsidies, and must make publicly available the plans it has under 5 U.S.C. §552.
12. One of the earliest clients of the GBLS Homelessness Unit presented a perfect example of the type of Catch-22 that PHA verification requirements often create. Our client had been homeless for two years as a result of the abandonment of his single-room-occupancy building by the owner, and its subsequent condemnation. The PHA in his hometown, a working-class suburb outside Boston, required him to provide verification from that landlord of his suitability as a tenant before it would approve him for public housing. Of course he couldn't provide such verification because the landlord was long gone: that was the reason he was homeless. After our office intervened and threatened to sue if the PHA didn't at least issue a decision on our client's eligibility based on his having provided all the requested verification he could obtain, the PHA accepted our client as a tenant, and he was housed within ten days!
13. After homeless advocates pointed out to officials of the Boston Housing Authority the particularly adverse effect on homeless applicants of the BHA's requirements that applicants list *all* their "residences" in the prior five years and provide verification other than from relatives from each location, the BHA official in charge readily conceded that BHA had never looked at its

admission practices from the perspective of the homeless, despite the fact that a very large proportion of current BHA applicants are homeless. The BHA agreed to alter many of these adverse practices.

14. This eligibility restriction remains in effect until HUD issues regulations to implement the November 1990 change in the federal statute.
15. Many housing advocates, as well as PHA managers, are concerned on a practical level that it is bad housing policy to "mix" substantial numbers of handicapped, particularly mentally handicapped, tenants with elderly residents of public or subsidized housing, and that such mixing will result in diminished quality of life for both the aged residents and the disabled, as well as leading to disproportionate "housing failure" for the handicapped. Any such concerns, however, should affect only the remedy sought, including "reasonable accommodations" to assist the mentally handicapped to maintain their tenancies, and not whether advocates seek to enforce the rights of the handicapped to public and subsidized housing.
16. *Cason v. Rochester Housing Authority*, 748 F.Supp. 1002 (W.D.N.Y. 1990).
17. Advocacy aimed at procedural fairness, such as adequate notices, reasonable verification requirements, and fair hearings, presumably inures to the benefit of all applicants, although such efforts may not be positively received by all nonprofit housing developers in their role as landlords.
18. One could also counter as to why this challenge should apply to the validity of representing applicants for a limited resource, but not to the defense of tenants facing eviction from the same limited resource. Many legal service programs devote substantial resources to such eviction defense (as I think they should).
19. For example, W. Simon, "Legality, Bureaucracy and Class in the Welfare System," *Yale Law Journal* 92 (1983): 1198.
20. See generally, B. Sard, "The Role of the Courts in Welfare Reform," *Clearinghouse Review* 22 (August/September 1988): 367.
21. Whether increasing the supply of rent subsidies to be used to pay uncontrolled rents to private landlords (as opposed to the construction, substantial rehabilitation, or purchase of publicly or nonprofit owned housing) is a good or the best use of public housing dollars is a serious issue of housing policy, which is beyond the scope of this article. However, the potentially greater accessibility of income maintenance types of housing subsidies to the politically and socially disfavored, for example, the homeless and traditional victims of prejudice, like racial and ethnic minorities, is a vital element of such an analysis.

Streets Are for Nobody: Pat Gomes

Twenty-five; two children. Has apartment; worked part time for Salvation Army Daycare Center, a facility for the children of homeless women. On welfare. Currently in Career Development Training Program.

I've been out of my mother's house since I was fifteen — and I've been on my own more or less. Then I got pregnant with my daughter and I moved back to my mother's house because where I was living was like a drug-infested area and I didn't want my child to grow up in that type of atmosphere. So I moved back with my mother. Me and my mother never got along to begin with, you know.

I went to Welfare and they put me in a shelter. And I enjoyed that because there was people there for me, you know what I mean? Anything I needed, I could get. I'm not sayin' that everybody should become homeless, you know, but there's people there for you, so you shouldn't feel too bad bein' homeless.

That's one thing I liked about bein' homeless, you know? If you need food, there's food pantries open to feed you. There's shelters that give you hot and cold things. When you need clothes, there's a clothing bank. There's furniture banks, you know. The thing that hurts the most is when you first get your place they cut you off all that.

So now it's like, I don't have nobody there to tell me, "Well, this is how you gotta budget your money, you can only spend so much, you know." I never had to cook for me and my daughter or go food shoppin'. I go food shoppin' and it's like I buy everything I want and I can't afford everything I want, you know what I mean? See, I'm not into this — this is my first time having my own spot, you know what I mean? So, it kinda messed — financially, I can't say I'm set, you know, but, look, I'm trying. You know, I'm working. I'm not just waitin' for the welfare check. I'm workin'.

When I was in business, it was borin'. I got tireda sittin' at a desk all day. You know, here I get to meet new people, you know, I get to help children. I have fun. And my kids love it here, you know, but they don't pay me enough to . . . to like live off of it. I wish I could have this job forever. If they was payin' me for full-time pay, you know, I wouldn't quit the job. I'd tell Welfare, hey, they can take their checks and stick 'em, you know. But I need them now and I'm gonna stay here for my children.

I'm gonna go back to school for child development, I think. I can be a teacher and make good money. Good money. But I would always want to work in a day care.

I wanna be able to take my kids to the aquarium and places like that. That's the only reason why I like this job, you know, because they get to go out places, and the

Interviewed by Melissa Shook, July 2, 1990, Cambridge. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

homeless children as well as my own, they get to experience new things. They don't have to just stay in the park or stay in the shelter. They get to see things that they haven't seen. Go to circus, learn about animals, things like that, you know that? Like TeeTee, she went to the aquarium. She came home — "Mommy, I seen the turtles, and Mommy, they were swimmin' an' —" She just kept goin' on and on, and you could just see her face was so lit up, you know, it was wonderful. And even the kids here, you know, "Oh, wow, the bird, the tree," you know. "Look at the bubbles!" They get excited off that stuff.

That makes me feel good to see that a child is enjoyin' herself and because I'm a part of that, you know, that makes me feel good. So, now, I try to get TeeTee to the circus, the library, anywhere, just — you know — so she can get that little spark in her eyes, you know, and I be happy. I'm happy when she gets that spark in her eyes, you know, and I never got to do them things when I was a kid, but my kids aren't gonna live the life I lived. They gonna enjoy life, if I can help it. My life sucked. Sorry. It sucked. I been drugged, deprived, and it hurts, you know. I'm happy because I have kids, and my kids make me happy. 🐼

The Housing Affordability Slide in Action

How Single Mothers Slip into Homelessness

Elizabeth A. Mulroy

This article presents the concept of a housing affordability slide toward homelessness, then analyzes how single mothers living in the Northeast experienced the stark reality of the slide in the summer of 1991. Discussion on critical elements of the slide includes a resource squeeze between high housing costs and low incomes, frequent residential mobility, limited locational choice, and multiple stress burdens. Single mothers speak in their own voices to explain their experiences of the slide and what its impact has been on them and their families. Policy recommendations cover linkage between family well-being and national urban policy and a court-ordered five-year housing transition plan.

I was in the hospital after I fell from a second-story porch and injured my head. I was in a coma. My utilities kept adding up even though I wasn't using them. They kept adding up. How could I have paid them? They put a collection agency on me. Lawyers sent me letters. I had \$500 in back bills not including medical. They drove me crazy. I told them I would pay when I can but they told me they are going to put me in court.

Maria is a Hispanic eighteen-year-old single mother with a two-year-old daughter, whose only source of income is Aid to Families with Dependent Children (AFDC). She receives \$446 a month plus food stamps. At the time of her accident, she was living with her child in a small apartment in the private rental market in Worcester, Massachusetts. She tried to stretch \$446 every month to meet all the basic needs of her child and herself. In order to pay her rent, she sometimes let a utility bill slide. The accident and the subsequent unpaid bills created a crisis and great stress for her. Because Maria couldn't pay both her rent and the back bills, she and her daughter became homeless.

All names have been changed to protect identity and privacy.

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The burden of coping with the rising costs of living has fallen disproportionately on the poorest households, especially on those consisting of single mothers and their children. In the 1980s, a new housing crisis emerged: the intertwined issues of housing affordability and availability. As their incomes declined and their housing options were restricted, low-income single mothers found themselves in a housing affordability squeeze. Unable to pay escalating rents or rent increases, they became vulnerable to eviction, overcrowding, and social dislocation. In effect, they have been on a collision course with the housing market. Housing affordability threatens family well-being by exhausting family resources, which then makes mothers and children susceptible to the cumulation of multiple stressful life events within a relatively short time. The outcome is a housing slide to homelessness for thousands of families.¹

My article first outlines as background to the present crisis some trends and changes in the housing market and in family formation over the past fifteen years. It then describes four critical issues in the slide: (1) the resource squeeze; (2) frequent residential mobility; (3) lack of locational choice; and (4) multiple stress burdens. Single mothers give firsthand accounts of their experiences in the Northeast during the summer of 1991. The voices of the single mothers reported here are part of a larger study of stresses and supports of single mothers across the life span. Finally, I suggest policy directions for the 1990s.

The Trends

In the decade of the 1980s, families headed by women were found to have more housing problems than any group living in substandard housing in America.² In part, this phenomenon was a result of the shifting demographics of the past fifteen years, which resulted in a major increase in the number of poor, single-parent families. Of these, especially families headed by females were competing with all other renters for a reduced supply of affordable units in the housing market. In 1988, more than one in five U.S. households with dependent children were headed by single parents, up from fewer than one in ten in 1960. That increase is due primarily to marital dissolution and secondarily to the growth in numbers of families headed by never-married mothers. Prior to the last three decades, single-parent families usually resulted from the death of one of the parents.³ The persistence of these trends suggests that only 37 percent of white and 9 percent of black children born in 1980 will live with both of their natural parents through the first fifteen years of childhood.⁴

Economic Vulnerability

Single-parent families have captured the attention of policymakers and the general public as a social phenomenon because of their economic problems. A lowered standard of living is associated with single-parent households; many studies point out the adverse impacts of childhood poverty on the well-being and future achievement of children.⁵ The family structure itself is often blamed for the problem, rather than such external factors as labor market events, which have been found to bear more responsibility than family events for transitions into poverty.⁶

Single-parent mothers are working mothers, yet they are still poor. For example, two thirds of all single mothers are employed either full or part time,⁷ yet their annual median income is \$12,979. This amount represents only 32.4 percent of the

\$39,995 median income of married-couple families, and only 38.7 percent of the \$33,458 median income of all families.⁸ Since family income purchases resources and services that sustain family health and well-being, families headed by women are at a severe economic disadvantage in competing with other households for scarce basic needs such as affordable housing.

Housing Costs and Availability

Housing costs have increased for everyone, with homeowner and rental costs outpacing increases in other commodities.⁹ These costs have outstripped the growth in real incomes, even during a time of economic recovery and growth. Therefore, the proportion of income spent on shelter has increased for homeowners and renters, even for units of comparable quality and characteristics. Between 1974 and 1987, as median incomes for single parents declined, gross rents for their households rose. The median rent burden (percentage of gross income spent on gross rent) therefore rose dramatically, from 34.9 to 58.4 percent. Half of such households were spending more than 58 percent of their incomes for shelter in 1987.¹⁰ This resource squeeze, although staggering for any family, leaves few remaining dollars to cover the low-income family's other basic needs like food, clothing, medical care, child care, and transportation, let alone a chance to save money for large unexpected bills or a catastrophe.

One reason rents were pushed up was a mismatch between supply and demand. As the demand for affordable rental housing units was increasing, the supply was decreasing. In strong housing markets, affordable units have been lost to condominium conversion and higher-rent tenants; in weaker markets, units have been lost to disrepair and abandonment. Beginning in 1981, deep cuts in federal programs for the poor had gradual and profound impacts. For example, housing comprised 7 percent of the federal budget in 1978, but only a tenth of that amount by 1988. New construction programs have been eliminated, and early projects financed through the Section 8 New Construction Program, which provided contract guarantees for fifteen years with the possibility of renewal, are now expiring. Cutbacks in the Section 8 Existing Rental Assistance Program, through which individual low-income families search for units in the private rental market, have, in some urban areas, resulted in long waiting lists of ten to twenty years for the reduced supply of certificates being issued.¹¹

Units developed under public housing subsidy have been lost through aging and disrepair. Because of declining funds for maintenance and capital repair, local housing authorities have removed many units from occupancy. When major rehabilitation and reconstruction of public housing do take place, a trend toward density reduction to enhance the livability of major urban projects has further reduced the supply of units.

The Housing Affordability Slide

The Resource Squeeze

The resource squeeze is so tight for Janice, a black nineteen-year-old with three small children, that she is on the brink of homelessness, paying 82.4 percent of her monthly AFDC income for a one-bedroom apartment in the private rental market in Chelsea, Massachusetts. She sleeps in the living room, and the children share

the bedroom. Initially, she doubled up in her mother's three-family house in Dorchester, Massachusetts, but it became overcrowded. Janice describes her housing conditions this way:

I never thought being on my own would be so expensive . . . Someone broke into my apartment and I called the landlord to fix the windows that had been broken and everything — that was in February. My radiator's broke, it went down in March. I haven't had hot water in two months now. It's rat infested in my ceiling and in my floor panels. It's a disaster . . . The street I live on is okay, but drugs are a very serious problem in the neighborhood on the weekends.

Janice has sought the help of Greater Boston Legal Services and is on nine housing authority waiting lists for public and assisted housing.

The resource squeeze also has a severe impact on separated and divorced women who are homeowners. They frequently fight to hang on to the property for as long as they can. Astrid, a white thirty-two-year-old mother of three who has been separated from her husband for eight months, explains:

I'm scratching at every dime I can find. It's a \$1,200 first mortgage and a \$200 second mortgage, plus utilities. I'm just barely making it. And then there's \$124 for day care and the groceries and clothes; come on, I don't even know how I'm doing it, but I vowed to keep the house. As soon as he left me he wanted me to move out and into an apartment. I lived my whole life to get this house. I'm going to do everything in my power to keep it. If I can't do it, it won't be because I didn't try . . . If I do have to get an apartment, I'll probably never get another house.

With children ages sixteen, fourteen, and four, Astrid works full time as a secretary. Although she has earnings and receives child support regularly, her rent burden is still 67 percent of her income. She describes how she juggles her budget and priorities to meet her fixed housing costs:

My daughter is going through a lot of dental work now — about \$5,000 that is uninsured — but what are you going to do? It is your kids. There's no savings or money set aside for emergencies. If my car ever broke down, I think I would lose my house, because who is going to have that kind of money . . . I don't ever go to the doctor. You're supposed to go to a gynecologist once a year. I think the last time I went was three years ago. Dentist? I need to go but I don't have the time or money for me. If a mother has \$20 in her pocket and her kids need something, it goes to the kids.

Despite Astrid's strong determination to remain in her home, the elements of her budget are fragile, and in large measure external to her control — lodged in the good will of her husband and in the labor market. For example, if her husband reduced or stopped making child support payments for even one month, she would have insufficient income to make the first mortgage payment. If her work hours were cut back to part time, or if she were laid off from her job, she would have insufficient child support to cover the first mortgage.

Only half of all single mothers receive child support, and only half of those receive the full amount due. Studies show that when child support is paid by absent fathers, the money most often arrives in the early phase of marital dissolution and is reduced

or stopped over time.¹² Since Astrid had been separated for only eight months and not yet divorced, she may experience a serious reduction of her income package, forcing displacement from her treasured home because of inability to pay.

Residential Mobility

The level of stress increases with each turn on the housing affordability slide. Unlike household expenditures for food or clothing, which can be cut back or postponed, housing costs are fixed. Decisions to cut back on household expenses by not paying utilities or the rent lead to service termination — as Maria found out — and eviction. To reduce rent burdens, households are required to relocate or make changes in family composition, for instance, moving in with relatives or friends, which is expensive and stressful. Faith's experience is just one example.

Faith, a white forty-year-old woman with two children, sixteen and ten, had owned two homes with her husband — the first a small house they sold so that they could purchase a larger one. Then her husband lost his job, and they had a hard time paying their bills. After twenty-one years of marriage, their relationship broke down, and they filed for divorce. In the next year of marital bitterness and anger, the bills piled up — utilities, mortgage, car, and so on. Despite taking out a second mortgage and borrowing from relatives to pay those bills, they were forced to sell their \$200,000 house for \$149,000 in the depressed real estate market.

Subsequently, the son having gone with his father, Faith and her daughter moved from their suburban single-family home into a two-bedroom apartment in the city of Worcester, for which the rent is \$800 per month. In order to afford it, Faith works sixty hours a week at two jobs, as secretary for a large corporation in the defense industry and cashier in a retail store. She knows the work overload is very stressful and bad for her health, but she has to keep working to pay the rent and take care of her daughter. She had to begin treatment for colitis and depression and talks of being close to a nervous breakdown.

Even regulations of federal housing subsidy programs can force residential mobility on low-income single mothers and their children. Nadine, for example, a twenty-one-year-old black single mother of a three-year-old, who is four months pregnant with her second child, is about to be displaced. For many years, Nadine has lived in her mother's subsidized apartment in a stable family situation. After the housing inspector last visited the unit, the family was informed by the landlord that Nadine and her child would be "off the lease" in October; otherwise, the unit would be technically overcrowded and would not "pass inspection" to meet housing quality standards for density.

Nadine is in a full-time school setting for parenting teens, working on her GED. She feels she needs housing stability to stay in school. In the next four months, she will be embarking on the housing search that will result in very few options. She has already applied for assisted housing and been on Section 8 waiting lists for three years. If she cannot find an apartment and stays on with her family, her mother, stepfather, and brother will be threatened with eviction.

Hortensia, on the other hand, has moved eight times in the past five years. At twenty-one, she has three children, ages three, two, and seven months. Hortensia, who is Hispanic, and her Costa Rican husband moved back and forth between Boston and Costa Rica to try to make the marriage work in his native land. When

the relationship got rocky and Hortensia felt rejected by his family, she moved back to Boston to be closer to her own family. She and her husband have been separated for fourteen months, and she hasn't heard from him in five months. She ended up on her own. She finally found a landlord who would rent to her and the three little children, but the rent for the two-bedroom apartment was *more* than her monthly AFDC income. Despite efforts through legal services, she has to move again. The severity of her housing affordability dilemma and the stresses from frequent moves are creating multiple burdens.

No Locational Choice

Four out of five single mothers live in the private housing market, but the costs in urban areas are beyond their reach, as the preceding examples indicate. Low-income single mothers usually turn to public and assisted housing programs for affordability. However, when single mothers like Maria, Janice, Nadine, and Hortensia finally get to the top of a Section 8 waiting list and secure a certificate of participation, they still may not find a suitable unit or even be selected for tenancy. Many low-income single mothers who live in urban areas and try to rent with a housing subsidy find the market to be full of "land mines" and invisible barriers. The Section 8 program is a laissez-faire concept offering affordable rent in a neighborhood of choice, provided the low-income family can search competitively with all other renters in the marketplace. However, many low-income single mothers are disabled searchers for these reasons: (1) they have no telephones with which to make and receive phone calls to landlords; (2) they have neither a car nor a driver's license and rely on public transportation to view apartments and be interviewed by landlords; and (3) they have no access to affordable day care outside their school setting to enable them to conduct a time-efficient housing search without children in tow.

Moreover, many landlords refuse to participate in subsidy programs for a number of reasons. In one study, 78.5 percent of all single mothers surveyed reported that the greatest barrier to using the Section 8 subsidy was landlords who refused to participate in the program, even though such discrimination is illegal in most rental arrangements.¹³ Even when laws do offer protection, the process of filing and proving discrimination claims is lengthy, time-consuming, expensive, and discouraging. Turning away prospective tenants or steering "undesirables" to "appropriate" neighborhoods is a relatively easy matter, and discrimination is often difficult to prove.

Housing and the resource bundle. Low-income single mothers seek to put together a number of resources at once — housing, affordable day care, an education program, an employment and training program, counseling, and employment. The housing resource is the centerpiece of this "resource bundle," because it anchors the family and gives it the stability to focus on accessing the other resources. Yet it's frequently the last attainable item in the resource bundle.

The bundle is often held together in a fragile collaboration among many public and private nonprofit agency programs. The geographic location of the affordable housing, when it is obtained, is central to making the whole bundle work. Problems and stresses develop when the housing location is not compatible with the rest of the elements. The entire resource bundle is then threatened with failure. Patsy, for example, is faced with such a dilemma.

Patsy is a black twenty-year-old, with a two-year-old child, who is enrolled full time, year round in a high school equivalency program for parenting teens. She dropped out of public high school in the tenth grade, but hopes to have her degree in 1992. Having found satisfactory subsidized day care in downtown Boston, she is able to go to school with peace of mind. Patsy comments on her housing choices:

When my mother kicked me out, Bill's family took me in. They live in an apartment in Harbor Point and lived there for years, all through the reconstruction from Columbia Point public housing. They are wonderful, warm people, accepting of everyone, of all races — very strict — but they care about you. They taught me things . . . like how to get a telephone and how to pay bills. I wanted to stay at Harbor Point to be close to them, to the baby's father, to the baby's child care center . . . The neighborhood is clean and safe. I applied to stay there in my own apartment, but I couldn't get a Section 8 or 707 certificate. I was on a waiting list at the housing authority for two years. They gave me two public housing projects to choose from — both far away. I chose this one because it's a little closer to the day care center than the other one, but I've only been here three months. I don't know anybody out here . . . I don't talk to no one. It's a very bad neighborhood. Someone got killed under my window. I want to transfer out.

From her present location, it takes Patsy two and a half hours to get from home to the day care center and then to school on public transportation. Multiple bus transfers and tight connections add up to five hours of commuting a day. She is motivated to complete school and managed the commute during the summer, even though she is exhausted when she gets home at five o'clock. She hoped that she could do it during the winter months, despite the cold weather and long stretches of walking that the route requires. She needs and wants to live closer to school and day care. A better geographic location would reduce the stresses created by her lengthy commute and having to live in an unsafe neighborhood.

Multiple Stress Burdens

These experiences suggest that a woman who heads a family becomes provider, shelterer, and caregiver, often on a severely limited income, which renders her resource poor, house poor, and time poor. For such women, the pressure of meeting housing costs on limited incomes is the critical factor that sets the housing affordability slide in motion. Once that slide has begun, stressful burdens accumulate along the way, as expressed by all the women quoted above. Families who are unable to get off the slide find themselves homeless and demoralized from living in substandard housing, unsafe neighborhoods, and overcrowded conditions, or from going through court appearances and eviction.¹⁴ These life events, along with job loss and divorce, are intertwined with single parenthood and represent some of the most stressful experiences in American life.¹⁵

Policy Directions for the 1990s

Diversity in Families

Demographic trends suggest that increased diversity among household types and in family structure will likely continue into the twenty-first century. As 1990 census data indicate, some 55 percent of U.S. households consisted of married couples,

down from 60 percent in 1980, and 30 percent were nonfamily households, up from 27 percent in 1980.¹⁶ Single-parent families continued to be the fastest-growing household category in the 1980s.¹⁷

Will mother-only families continue to be poor? They will if existing institutional arrangements do not change. In a longitudinal study of family structure involving 707 children, Duncan and Rodgers¹⁸ found that life in a single-parent family and experience with poverty are much more prevalent and persistent for black children than for white. The economic status of mother-only families obscures the critical fact that family structure is less important than other factors in affecting the economic well-being of children. The role of labor market events appears to bear more responsibility than family structure in transitioning both two-parent and one-parent families into poverty. For example, although Astrid and Faith are employed full time as secretaries for large, multinational corporations, they are still resource poor. Also, it was Astrid's husband's layoff that sent the family into a lower socioeconomic bracket, and Astrid's earnings alone are not sufficient to change that status. Therefore, policies that target labor market events for all families and increase hourly wages; expand benefits packages, including affordable housing, health, and child care; expand equal employment opportunities; and break down restrictive male/female occupational categories for all women will improve the economic well-being of single-parent families.

Family Well-being and National Urban Policy

National policies for cities are critical to solving the most serious of the nation's problems, such as homelessness. The long-term direction of national urban policy should change to incorporate family policy concerns. In the past decade, as the crisis in housing affordability and availability grew, poor families received fewer services in other areas as well. Between 1982 and 1985 alone, \$57 billion was cut from federal programs for the poor. Numerous inner-city urban residential neighborhoods have declined into combat zones where children and adolescents succumb to drug abuse, gang violence, and homicides. Parents live in fear of letting their children go outside, and they are increasingly powerless to control the boundaries of encroaching drug traffic. The social dislocation of families should not be a surprising phenomenon in the face of national policies that have let our cities decline.

Policies that require absent, employed fathers to transfer more of their incomes to their children and increase benefit levels among public transfer programs would improve the economic well-being of many single-parent families. However, male unemployment is high, especially among young males of color. Only one of the men in the lives of Maria, Janice, Hortensia, and Patsy is in the work force, and he is employed only sporadically. Each of the other young men is disabled, unemployed, incarcerated, or in a full-time high school equivalency program. Unemployed, undereducated fathers are unable to pay adequate child support, despite court orders telling them they must.

Two-parent families will not become a reality for the very poor in urban neighborhoods until young males, especially those of color — the forgotten fathers — have resources for quality public education, high school equivalency programs, technical job training, drug treatment programs in the cities, and other services needed to prepare them to enter the labor market to earn a "family" wage. National urban policy

should embrace these family priorities. Such policy in the 1990s should again specify the economic and social investments required in the cities.

State and Local Targeted Programs

At the state and local levels, there are many junctures at which special programs and services can assist the poor in blunting the injurious effects of the housing affordability dilemma. Hortensia and Janice are receiving much needed assistance from a legal services corporation. Nadine is receiving comprehensive prenatal care *and* housing search and advocacy assistance. Hortensia, Janice, Nadine, and Patsy receive classroom instruction for the high school equivalency diploma, job skills training, vocational counseling, and drop-in child care. Maria was accepted into a service-intensive transitional housing program. Maria is there now, and will be much better off for her stay, although it is time limited for all residents.

Maria and others who participate in such valuable programs will eventually be looking for an apartment again in a hostile private rental market or competing with thousands of other poor families for scarce Section 8 certificates. They may also get a chance to live in public housing, but the unsafe environment of some developments may keep them living in fear and stress. Without permanent, affordable, habitable, and nontransient domiciles, the housing affordability slide is doomed to be repeated.

Five-year Housing Transition Plan

More sensitivity needs to be shown to the housing element when mothers experience marital separation, divorce, or request child support. Public institutions such as the courts are in a unique position to assist all single mothers with their housing problems by requiring a five-year housing transition plan as part of the court record. The purpose of such a program is to plan for family residential stability over time in order to reduce the housing affordability squeeze associated with a person's becoming a household head on inadequate resources.

Marital dissolution and child support orders bring thousands of separating, divorcing, or never-married families before the courts every year. Housing arrangements for children have not been a matter of interest to the courts unless a home is part of a property settlement. Family courts could hear findings on a plan that sets forth children's housing and living arrangements as a matter of record. The plan would require stipulation of

- public and assisted housing resources, costs, and availability in the family's location of choice.
- private rental market housing and home ownership opportunities, cost, and availability in the family's location of choice.
- length of public and assisted housing waiting lists.
- application procedures, regulations, and restrictions for each federal, state, and local assisted housing program.
- costs and benefits of enabling a single mother and children to remain in the family home, if one exists, in preference to other housing options.

With increased knowledge and understanding of the mismatch between supply and demand, the courts could require

- speedy access to housing programs for low-income families where available.
- child support orders that reflect the actual cost of sheltering children in the private market, or the family's share of subsidized rent.
- housing to be a constitutional "right," through which broad state and local policies and initiatives would result in preserving existing affordable housing and reducing displacement of single parent families.

Homelessness can be prevented for thousands of single-parent families whose "problem" is housing affordability. Rather than blaming family structure or individuals for causing problems, public consciousness and policy attention should be directed toward solving the problem by increasing the supply and availability of affordable rental housing. With lowered housing costs, single-parent families would have more income to cover other basic needs that enrich children's lives and improve the family's level of well-being. While others have recommended a myriad of ways to increase the supply of affordable housing,¹⁹ my purpose here has been to present the concept of a housing affordability slide and to observe the slide in action through the voices of single mothers who experienced its stark reality during the summer of 1991.

Low-income single mothers are in a double-bind situation. Even if the public consciousness recognizes the pervasive importance of housing, the single-parent family structure remains morally ostracized and on the margins of society. The challenge for the 1990s will be twofold: to work toward the necessary evolution of the housing market, and, simultaneously, toward a public consciousness that will accept and value all family forms, including those headed by women. ♀

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Twin Peaks

Vince Putnam

Wafted by fog
surrounded by tier upon tier
 of clinging little houses
matted by macadam
 lanes
running up down around
to spire crowned apex
 zenith of horizon beyond
the stars and blue
 pacific
now lost in a sea of haze
dew drops cling on giant kalanchoes
 above the azure
wind swept sky of
 san francisco

I sit alone
in a small cafe in castro
 and soundlessly watch the
soft faces and eyes of
 young men
in wide open flimsy wispy shirts
the coffee cup is refilled
 the morning becomes late
as youths begin to roam in
 parks and gloom
more
and
 more
 and
 more
and yet i am alone
my days yet are few
 and return forth with
from this paradise shall i
 hence

Evening has come as it must
and i sit reflecting on the
 margins of my days.

steep and pitiless winding
 hills
traversed by clinging clanging
 cablecars

an old man totters from
a trackless trolley
 he drops his cane
 ping!
i pick it up he smiles a toothless
 grin

night begins its long descent
from the spire guardian on the
 hills
kiosk like it stands

more more more
 more my pleasure
 surges in

last days memories
on sand strewn roads
 pointing at the western
 sea

Vince Putnam is a resident of Fifty Washington Square, Newport, Rhode Island. His work has appeared in In the Heart of the City, a literary magazine produced by the residents of Fifty Washington Square. He is pursuing an MSW degree at the University of Rhode Island.

I shall come back
filing dream memories
 in fluent afternoon
 evening reveries
coupled in the loving arms
 of one i held close
 her brown hair
 and musty aroma
 accented by the lamplight
 in transit time
send now a color of mauve
patterns on the wall
 fire and silver in the creek
 tonight
as i cabled-trolleyed my
 way
to here my san francisco
 home
 215 Henry on a hill called
castro
 above the city of love
 by the greenish-blue
 bay.

1978

Diary

Susan M. Fowler

An Entry, December 15, 1981

On December 15, 1981, I Susan M. Fowler just decided to write all about my life. I was born in Newport, R.I. I guess I should just start from the beginning. I was born on January 11, 1962. I don't really remember anything good about my childhood. I remember when I was in first grade, one time, I told my mother I was so smart the principal said I could skip a grade, but of course I was lying. My life is really a drag. When I was growing I just couldn't talk to anybody, I would kind of shy away from people, but I was always the hell raiser. I could never figure that one out. Here I am, just sitting in this old building writing on an old fashioned sink. This is a dump but I've seen worse.

Well, when I was about 10 I remember my brother Eddie when my mother would give him a bath. I would have to hold his hand because he thought he was going to die. Me and mother and father never had a good relationship until two days ago when I came home to live with them. When I was little and it would rain and thunder, like today, me and my brother and sisters would all lay in my bed holding each other's hands and I would comfort them. Its funny, why didn't they just go down stairs to my mother and father? I think they knew all about the problem but just didn't say anything, even though they were so young. See, I'm the oldest one in my family. If you want to call it a family.

Then, when I was about 12 years old I noticed my father never coming home or he would come home drunk and beat up my mother and me and Eddie and Joyce would stay upstairs and cry and listen to him break things and beat her up more. See, my father never had nothing when he was a kid. I guess his father beat him, too. That's what they say.

Then, when I turned 14, one night my brother and sister heard what [was] going on downstairs and asked me to go help my mother. So I snuck down stairs and hid behind a desk and he, my father, caught me and beat the living shit out of me. Then, I went back upstairs.

Susan Fowler, a former resident of Fifty Washington Square, Newport, Rhode Island, now lives in her own apartment in Newport with her two-year-old daughter and is "doing great." Her work has appeared in In the Heart of the City, a literary magazine produced by the residents of Fifty Washington Square.

My friend, Dottie, who lived one street over, told me she could hear the yelling all the way to her house. See, she was a foster child who had it better than I did, even though my father had a garage and owned his own house and towing business. See, me and Dottie were good friends. One time, I don't remember the day, she told me about Henry Norberry, who was an old guy about 60. He was our friend, see, he worked building things. He would give us a hammer and some nails, a few scraps of wood and we thought we were building something. Then, one day Dottie said "I have to show you something."

I said, "What is it?"

She said, "Look in the garage [where] Henry is." I looked and saw him hanging by his neck with a rope. See, Dottie was like me, scared of people. She was even too scared to tell her mother, Mrs. Marshall. She told Jerry and Greg, so when I saw him I ran up the street and told this guy who owned an oil company and he thought I was lying. So, he called my father and told him I was telling lies and my father came and got me and I told him the whole thing and we took the tow truck to Dottie's house and Greg and Jerry and Dottie were standing across the street by the door of Henry's garage. So then, me and father got out and I showed him Henry. Then the police came and the morgue and then after a while everybody forgot about him. But not me.

Diary Entry, December 17, 1981

I thought I'd talk about something today like what I did today. Well, since I came to live with my parents about a week ago I got a job with the Johnsons stripping paint off furniture. See, I use paint thinner to get the paint off furniture. I would work in it, the paint thinner, for about 10 hours a day and that stuff just gets you so stoned.

See, I'm writing all this at 3 o'clock in the morning and I've been up since 8 this morning so you can just imagine how stoned I am. See, I love to get drunk and do many drugs to get away from all this problems life brings. Like reality responsibility, every people that way can just be alone in this big world. See, I had to leave Newport, R.I. because I asked so many times — they just stopped coming to get me. I do some downs and drink all day long, loved every minute of it. So, why should I lie about it. Some people just don't understand how good they have it.

Well, to get back to December 15, 1981. After Henry hung himself we just went back to the same old shit, everyday me and family just fight and arguing about everything. See, my [father?] made fund of the [way] I dressed, if I ate too much I was a damned pig, if I wouldn't eat my peas I'd probably get punched in the head. See, my father used mine and my mother's head as a punching bag. No one ever really loved me, I don't [k]now why. Then, as you get used to it, it's not so bad, because after a while you just don't know how to accept it, love I mean.

Well, it doesn't really matter anyway. While I was a kid I always wanted to be a police officer. The reasons then were so I co[u]ld arrest my father and throw him in jail, so he wouldn't hit me and my mother any more. And now that I'm 19 years old, the reason is so I can help juveniles, kids like myself, with the problems of growing up — like drugs, alcohol, abused children, sexual abuse, and all the work that goes with it. See, I think with my background of all these above situations which I've gone through I can benefit any community.

See, I know all or about all, most of what [social workers?] and police do, because I used to work for the Newport Police like a snitch. But I didn't call it being a snitch, I called it helping the community of Newport get better. See, I would bring an under-cover cop in a bar. See, the police would know if something went wrong because I would have a bug or something like that hooked up on my clothes so nobody could see it. After I brought the cop in the bar, I would set up a deal with a junkie to sell the cop some drugs. The cop who was with me [was named] Joe, and the other cops [Kelly and Burns, the cops I would work for] and I was called Joe Two. After the junkie sold Joe the drugs we would just get in Joe's car and drive off. Then in two or three months when everything was forgotten, the police would bust them.

Of course, the police, Kelly and Burns, would pay me twenty dollars. Then I could get my own stuff or get drunk all day. See, they knew what I was doing with the money — they didn't care. They would leave me alone just as long as I would do them a few favors. Let's get back to drugs. I've done just about all kinds like downs, ups, coke, heroin, alcohol, you name it and I've done it.

Diary Entry, January 3, 1982

Well, today is January 3, 1982. On January 1, my uncle, Eddie Damron, asked the police if I could ride with them while they were on duty and I loved it. I told the police officer I was riding with all about how much I knew about Police work. I didn't tell him I had taken drugs before just in case I could be a police officer in North Carolina.

Well, to get back to me growing up, when I was about sixteen I got fed up with my father coming home drunk and beating us up and running around with other women on my mother. When I ran away, I remember that night very well. My father came home drunk as a skunk and started beating up my mother so I just made up my mind to run away from home. Then I climbed out my window and onto the roof and down to another roof, then jumped to the ground. Then I ran and ran and ran as fast as I could to the Newport Bridge and didn't stop running until I got to the bridge.

I was so scared, I wondered how I was going to get across it. It was pitch black out. Then I started to walk across but got too scared. So, then I started to hitchhike and two guys picked me up and asked where I was going. I made up some street across the bridge in Jamestown and they said there was no such street. They they asked my name and I gave them a fake name. I told them my name was Susan M. Smith. Then before I knew it I was at the Jamestown Police station. They asked my name. I told them that my father was at home beating up my mother and he called my family and told them where I was.

When he got there at the police station he was so drunk he had to bring a guy that worked for him at the garage up to the station so he could drive because my father was so drunk he couldn't even drive. The police in Jamestown gave me a card to call if he ever did it again but the guy was never in or too busy to listen and that same night I called because my father beat the fucking shit out of me, just kept punching me in the head. I finally fell unconscious on the floor. When I woke up I called the number the Police gave but I guess they just didn't give a fuck about me. I guess nobody did. I just don't [know?] about the world.

Well, I guess that's it for now. I wanted to finish watching *CHIPS*, a police movie on TV. Well, *CHIPS* is over now.

Well, after I ran away, things were never the same, They just kept getting worse. My [father?] would make fun of me — you know, how a family sits down to eat dinner? Well, if I didn't eat something he beat me and if I ate too much I'd get beat. So, I didn't know whether I was coming or going. Then, when I was about seventeen, see, our house burned down on New Year's Eve of '79 and we were staying at my grandmother's house and me and my sister, Joyce, and I were sharing a room and she turned away from the TV to go to sleep so I turned the channel and she started to scream and just about that time my father came home, drunk, as usual, and heard my sister scream and came up stairs and I think he really tried to kill me.

I could see it in his eyes, he just kept beating, punching and even tried to choke me to death. Then my mother came upstairs and begged him to stop. Then he finally did stop.

Then the next day I went to school and told my guidance counselor and she called a social worker and I showed him the bruises and he said, "Well I'll have to call your parents and ask permission to take you to the hospital and to take pictures to prove it in court." Then I told the social worker, Mr. Pickett, if he called my parents and asked them they were going to say no. Then I said my father will really fucking kill me then. After he said that I just said forget it.

Well, it just got worse. By then I was living with my grandmother and started smoking pot. Then me and Lou Bebee, a friend of mine, I was going to sleep over her house, but things got out of hand. We went and bought a bottle of rum and I drank that and smoked about five joints. Then we decided to go for a walk and I just flipped out in the middle of the street. Then the cops came and I ended up in a hospital in the nut ward for 5–7 days. Then I called Mr. Pickett back and told him then what had happened and told him I wanted to go to a foster home. So he set it up to go to a foster home. The day I went to the foster home I was 17 years old.

Diary Entry, January 15, 1982

Today is January 15, 1982. Well, I turned twenty years old, big deal. I just wish I didn't get any older, because I'm afraid of dying and going to hell.

Well, I found out my father is still an old drunk, because he went out and got drunk, but you see, I was at home just waiting. See, I am twenty years old now so when he came home I thought he was going to fight and be rotten and I was just waiting to kill him with a .22 calibre gun. But I didn't get to because this time he just went to sleep.

Well, to get back to where I left off at, after the foster home I ran away from the foster home because no one ever showed me love before and in the foster home the Beacons were nice and loving and I couldn't accept it. So, then Mr. Pickett picked me up to go to the shrink and [I] got drunk and went to see them anyway. When I got there they called the hospital and told them I was coming. Then I thought to myself, "Run for the door," but he blocked it and I was too drunk to escape. So then I tried to jump out the window but that failed too. But even if I jumped out the window I would have died because it was on the third floor.

Well, then Mr. Pickett, the social worker, took me to the hospital in Newport, the nut ward. He even let me bring my whiskey bottle. The Beacons came to see me and they said they wanted me back so I went back and still didn't know how to accept love. By then I was used to running the streets, sleeping wherever I could, taking all

kinds of drugs — see, then nobody had to worry about [me] and I didn't have to worry about anybody or thing.

You see, I could[n't] even eat at the foster home because I was scared because before I ran away from my father he would beat the shit out of me if I didn't eat my peas or I would get beat if I ate too much. So, you see, I couldn't deal with the foster home even though I felt loved and cared for. I'll never forget the day I went there, I felt relieved but scared, so I cried — can you believe that — I cried when I was 17.

So, then I ran away again and went to see my counselor at the junior high school, Mr. Kane, and asked him if I could have \$2.00 to take a bus back to Butler Hospital — a nice hospital. See, I went there before for drugs and alcohol but left, don't ask me why, because they were really going to find out what was wrong with me. Maybe they would tell me that I'm crazy or something, but the counselor wouldn't give me the money so I ran the streets for a while, then I went back to my grandmother's house where I stayed for a while.

Then one day I skipped school and met a girl about 25 named Marilyn Perkins. She lived on West Broadway. She was white and her kids were black but that didn't bother me. But it bothered almost everybody else in town. Then we went to their house and got so stoned. I loved this high. Then I called my grandmother and said I was going to sleep over a friend's house and she said go ahead. She said, "I don't care, you never come home anyway." Then she said, "Just stay out as long as you want to." So, then I hung up and said, "Well, she don't want me to [come] home or don't care if I come." So, I said, "Good" and just stayed gone for a couple of months. Boy, did I have fun. I just had one big party, one mind blowing party for about two years.

See, [Marilyn] would go this doctor in Newport, I think his name was Bumgartener, and me and her would go there on Fridays and she would get come-downs. They are called Nembutals. See, she would get them whenever she wanted and I got so I could take 5 of these and they would just blow your mind. Then I met John and was alright. See, he was black and if my father knew I was going out with a black guy he'd kill me. But who cares, I'd fuck anybody who showed me they cared about me.

Then the party was over. I took too many pills and took a walk up the street to the park and went to sleep and ended up in the intensive care unit in Newport Hospital, and my father came to get me and I said to the nurse, "Keep him talking while I run out of here because he was going to kill me." So, they did and I ran and ran so fast. My father was chasing me in his car and I got away. I hid under an abandoned house for about two hours. Then I went back to Marilyn's house. We just hung around getting stoned, man. Then the lights were shut off in the house, no water, no heat, no electric, and no food. So most of the time we stayed in the bars and partied. But then I OD'd and Marilyn OD'd and Mr. Pickett came to her house looking for me and saw the situation and took her kids away from her.

I seen [her] before I came to North Carolina and she has her kids back and had another baby by a white guy who she lives with now. See, the guy that was living with her when I lived with her went to this place called Talbot House, a rehabilitation for alcohol and drugs. I saw him there when I went there in June of 1981. He got better then I didn't. I just picked up and left. I felt it was better on the streets.

See, even though I was doing all of this I would go to school and even played on the Rogers High School basketball team. See, my coach, Mrs. Bagard, she knew what

I was up to but didn't say a word, just gave me dirty looks. Then when I was in 12th grade I quit the basketball team — too much pressure, it interfered with my drugs. I just needed more time for drugs. I just went to school for a free meal. I liked school.

I quit school and went to Virginia with this guy. I loved him. See, he's in the Navy, so we went to Virginia and lived there for a while. See, he's from Saudi Arabia, and see, I would dress up like a million bucks and act like a nice girl and he thought I was a nice, innocent girl up until this day. See, the Arabic people have different ways, they eat with their hands and dress in white robes and talk a different language. And have a different religion — Muslim. But I loved it — he would buy things for me, he treated me so good.

But he told me he wanted me to go back to Newport and finish school so I did and he said he had to go back to Saudi Arabia but we will write and see each other the next year, 1981. So, I went to Newport and finished high school and just started up where I left off. I met a guy in the Hell's Angels motorcycle gang. His name was Al and we lived in a junk yard in Providence. See, the gang would rob a drugstore almost every Friday and we would get blown out of our minds. I'd start seeing things. We did this for about a month or two, then I went back to Marilyn's house where we all had a big party.

I met a lot of strange people like Gary, Bobby, then I joined the National Guards — something like the Army. This was in the summer of 1980. I went to bootcamp — boy, that straightened me out, but when I got to a city I would get drunk and spend 2 to 3 hundred dollars on speed to keep me awake. Then I left that mess and went back to my grandmother's and just started partying all over again. I started going to this black bar. I had the greatest time here in this place. They called it the Mahogany.

One time this guy Clarence went out with me. We made love, I guess, and partied for a while. Then about two nights later he drove me to his house and a woman came up to the car and said, "Get out, white bitch" and I got out and hitchhiked back to the Mahogany. Then the next day a big fire truck came by and stopped next door so I went to see what was going on and this woman was there and asked my name and address and all that. Then she said, "Do you remember me?" I said no and she said, "Well, I'm the one who told you to get out of the car and then she said, "I'm his wife."

Boy, I didn't know what to do, but then we became friends and [she] became like a real friend who cared about me. Her name was Lorraine Page. She helped me stop drugs and alcohol even after what I had done to her but then her and her husband went back together again. That was a happy ending for them.

Diary Entry, February 14, 1982

Well, today is February 14, Valentine's Day. Nothing going on just another day. I'm so mad because nothing's going right. I've only lost 25 lbs and I need to lose 12 lbs before I can take the test to get back in the Army and I don't know if I can do it. And my father's been drinking and he told me my mother's screwing around on him and taking pills.

See, what happened was my father came home drunk one night and looked in the closet and saw a jacket and asked my mother whose it was. She said it was his. He, my father, said to my mother, "You're a liar." See, my mother bought the coat for

him 3 years ago after our house burnt down. He just didn't remember. I think he's going crazy.

My brother's washing his new car my parents gave him, or I should say, lent him \$4,000 to buy. You think they would loan me any money? Shit. Hell, no. Well, I was doing good until today. I don't know what I'm going to do. I'm thinking about just moving back to Newport R.I. and just going back to getting high and drunk. Nothing seems to work anymore. I stopped taking drugs and drinking — where did it get me? No where. So I just think if I start getting high and drunk again that will get me nowhere either. I just can't find a way out of this mess. Nothing seems to work. I have no friends here in High Point, N.C. and the friends I have in Newport just like me because I acted crazy and just didn't care. I would just give away money and drugs or just fuck them.

See, when I went to a bar a guy would come up to me and talk to me. See, I was just looking for a boyfriend or anybody to fuck. I was looking for a friend, a father figure. So I trusted people and at the end I'd fuck them because I'd trust them. They'd just take advantage of me. I wish I knew a way out. Now I don't trust anybody and when everybody goes to the beach I won't even put on a bathing suit. I have a lot of hangups.

I just can't find any answers to my problems. I think I'm going over the edge. See, one of these days I'm going to kill myself. I mean really do it. See, the other times I was just looking for someone to care, take me home with them, but now that I'm 20 I find out nobody gives a fuck about me and I'm too old for a foster home. My life is over before it even starts. See, when I was about 17 the social workers could have helped me find a home where someone cares and appreciates me, but the motherfuckers didn't care either.

I wish I knew what to do. The only way out is to die. This seems to me is where hell is. If there's a place worse than this world I hope I never go. I figure if I die, I'll go somewhere they call it paradise. Anything's better than this, Well, I made my mind up I'll go to Newport soon, as soon as I get the money. I bet the cops there will say, "Well, she didn't change any," but I tried and tried to be straight, and I was no pills, no alcohol, I had a job that paid \$175 a week. It just didn't work.

I can't live with my parents and brothers and sister because they're spoiled rotten, get whatever they want. I get nothing, no love no nothing. My father's a crazy drunk and my mother just lives in some kind of fantasy world. And I just keep looking for a way, that only way seems to die! When I die nobody will care, they probably won't even miss me.

I left North Carolina and came back to Newport, R.I. You should have seen me the night before I left. I got drunk as a dog then got on the plane and got drunk on the plane, came to Newport, went to see Lorraine Page, then I called the Police station and Norman Mathers said he would see me around 5:00. He said not to go to the police station and see him anymore because the new chief of police doesn't want me there anymore.

Then last night I went to an Alcoholics Anonymous meeting, left there about 10:00. They dropped me off at my grandmother's, then I went to the bar, the Wellington Cafe, and saw Jackie Warfield. Her husband's the one who sexually abused me as a kid. We talked and she said she knows me and what happened is in the past. Now, I was so glad she said that.

Then down from the bar I saw this guy — he looked like he didn't belong in the bar. I forgot about him and started to go to my grandmother's house when this cop car drove up behind me and the cop got out of the cop car and said, "Empty your pockets." So I did. All I had was a wallet with my license and other ID. Then the cop called me a liar, they must have thought I had some drugs, because then the guy I was telling you about in the bar, the one who looked like he didn't belong, then he gets in the cop car and says, "Here Miss Fowler, here's your ID."

I went home, got up this morning, went and took my test for the Army and passed the test. Then on Monday I'll go to Boston for a physical, then I'll be on my way to success. I'm going to be a Police Officer. Well, the day I was to go to Boston, the Army recruiter said I was too fat, the fucking jerk said, "Come and see me when you lose the weight." Then I said, "Fuck that" and got drunk.

Then a few weeks later I got a job in Salas's and one night on my night off I got drunk and me and Rosemary went to this fishing dock and went on a fishing boat and I grabbed a knife about 15 inches long and tried to cut my pants into shorts, don't ask me why. Then I went to Tony's house and left there but before I went to Tony's, me and Rosemary and some guy went in a little boat for a ride and we ——— a stick about the size of a ruler. We didn't go to ———.

Then when I left Tony's I was hitchhiking along Thames Street, the cop stopped me and said, "Only hitchhike where there are no parked cars," so I don't get hurt. Well then these people stopped to pick me up. Well so I thought, but this girl got out of the car, spit in my face and then punched me in the face. Well, then they started to drive off and a cop pulled up and arrested me. And I went to jail. My rights were not read to me, the cop just said, "Do you want to use the phone?" So I called my grandmother. She said she wasn't going to pick me up. I was mad as a fucking dog.

Well, while I was sitting in jail, I just wanted to know why I was arrested and not her. Well, later I found out why, and while I was in spraying the wall with blood. Then about 2:00 in the morning I was let out of jail.

Then the next day I went to work at Salas's restaurant. She said she would get a lawyer for me when I went to court. Then she called up Eddie Schuster, a Police sergeant. He said he would help when I got to court but he died the day before I went to court. Well, then I went to court and the girl that hit me in the face, her name was Dede Del Nero and the judge was Judge DelNero, which was her uncle.

So I had to plead guilty but I pled "nolo." I know I was set up because her uncle being the judge is a conflict of interest and the cops didn't even read me my rights. Then the judge gave me a fine for \$50 and court costs were \$13.50 and all I had was \$50. So I called my boss and she talked to the bailiff and he let me go to get some more money and come back and give it to him. So did you ever hear of such shit? I couldn't believe it. With all the fucking undercover work I did for those Newport cops and then they fucking arrest me and set me up like that.

They just used me and then spit me out like a piece of trash. But there was nothing I could do about any of it. Ain't that some shit. Well, then after that shit my sister got married and had a big wedding. The whole family was there. I loved it and my parents came to the wedding. I got sick of fucking Newport and the way I was treated by this whole town. Payback is a motherfucker and they will pay from the ass for what they have done.

Then after the wedding we went to my grandmother's house with my parents. Then the next day I moved back to North Carolina with them. That was in August of 1982.

Not Crying Wolf, Crying Reality

You see, my life is so fucked up. By now, I just OD on drugs, sometimes twice a day, get my stomach pumped and six hours later, back at the hospital again.

I'm still looking for love. By now, the cops and hospital are sick of this, after eight years, so they just send me to the nut house. I'm ill, so I told them I see things, I hear voices. Now, I've got everybody convinced I'm crazy. They tried all kinds of medication, nothing.

I quit drinking and doing drugs, so I applied for disability but I didn't get it. So, now I've gone straight and I can't get rid of my bad reputation or the past. I really never did any bad drugs, just pot, Valiums, Libriums, doing a lot of alcohol.

I got where I would used to get fucked up just enough to stay alive. A lot of time I would overdo it, almost killed myself about thirty times. Now, I would just pass out in the middle of the street. At first, the doctors were nice, but they just didn't understand. Then, the hospital would just call the cops, but I only got charged with one count of disorderly conduct.

Now, I've gone straight and as far as I'm going to get is a fucking unneeded security guard. So, I'm just going to go back to the fucked-up life, because what's the sense of trying anymore? I got everybody convinced I'm crazy. I'll never get any respect. I can never be a police officer. So, I'm getting ready to throw in the towel.

It seems when you're a fuckup, everybody hates you. When you're straight, they hate you. So, if I'm dead, they'll keep on putting me down and hating me. So, what's the fucking difference? You see, what matters is college, not street life, not what you know or have done or been through, but what you don't know.

That's what the public wants.

Susan M. Fowler
9/20/87

Letter to Nana, 9/20/87

I just needed love. But I never had it, so I don't know what it is. Yes, I just need a little love, but I guess I'll never know. It's too late now.

Dear Nana

I'm writing to you to let you know I'm going away, and I won't be back any time soon. I'll write when I get to where I'm going, please don't worry about me. I'm 25 years old. I can take care of myself. I just need to start over somewhere else, it just seems I can never do anything right, never could. You know, it seems everybody knows that, I'll be back someday. Well, that's it.

Diary Entry, September 20, 1987

At work in Providence at Bank of New England. I'm just sitting here, wondering what the fuck I'm doing. I have quit drinking now for 1½ months. Everybody says, "Quit drinking and everything will straighten out." That's a fucking lie.

I feel like shit. Well, I got back into the National Guards. I've been working for over ten months but I still hate myself, don't trust a motherfucker. I still hate my father because he doesn't love me and nobody believes me about the sexual abuse Barry Wakefield did to me. Nobody understands I just can't forget all the beatings from my drunk father and about the 9 years of sexual abuse.

Now I find myself riding by this guy's house who sexually abused me. I even call him on the phone, give him crank phone calls. I think about this 24 hours a day, about how to kill him, like when I hitchhiked, he sometimes tried to pick me up a long time ago. What I'll do is put some drugs in his drink, tie him up, put a string around his dick, then wire it to the door to a room that is open, put gags in his mouth, just tease him, make him suffer till it hurts him like I've been suffering for the past 25 years, then walk out the door, slam the door and off comes his dick and balls and he dies a slow and painful death.

This is why I'm so fucked up, hate myself, hate everybody, just about don't trust a soul, ran away from home, was in and out of foster homes, drank alcohol till I was so drunk [I] almost died on numerous occasions, from alcohol, then I'd take a bottle of pills, smoke a bag of dope, cut my wrists, then still live through it. What a fucking shame. Live on the streets of Newport drunk, doped up 24 hours a day, turned to prostitution, just about fucked all bartenders — Nick Barbank, Jamie Sullivan, Dan.

Now that I've got a good job, don't drink, I'm still fucking up. I've gone straight but just can't forget the memories of abuse. See, it all started when I was almost 5 years old. Barry and his wife Jackie Wakefield were over the house with their kids. My mother and father and us kids, Eddie, Joyce and me. Well, everybody let Barry volunteer to babysit the kids, all the kids were playing. Barry said "Susan, come here." Nobody heard, so I went. Me and him went to the cellar and he showed me pictures in a Sears catalog, showed me bra underwear, said, "Does your mother wear this? Have you ever seen your mother and father naked?" Then he started feeling me, then he would come by all the time.

Everybody was so drunk, who gave a fuck, my father getting worse with the beating on us kids and my mother. Then Barry would come over, volunteer to take all

the neighborhood kids to the beach, movies, ride, but all the kids went swimming or watched a movie, or went to play. He would lock me in the truck and stick out his dick. Make me suck it, pulling my hair, holding my head and mouth on his penis.

It got so bad, when they were having drunken parties, raising hell downstairs, I would hide under the bed or in the closet almost all night until everything got quiet. Then Barry would sneak upstairs, make me do oral sex to him until my mouth hurt. I'm about 7 years old now. This went on till about 12 years old. My father by now was fucking everybody in town, staying away from home for weeks. By now we were getting punched, hit with fi[s]ts, belts, 2 x 4's. Then I got my period.

My mother and Jackie, Barrie's wife, were best friends. Then one day Barry took all the kids for a ride, pulled me aside, pulled down his pants, and pulled down mine. I'm 11 or 12, I can't remember. So he said, "Here, you got your period." I said, "What?" Then he said, "Period." He sat on the ground and pulled me on top of him, put his penis in me. I cried, it felt like a knife cutting through me. It hurt my whole insides for about a week. I bled for about 2 days.

After that I always cried, even more now. I can't remember going through elementary school while all this was going on at home. The teacher would make me sit in front of the mirror all day long because I always cried and was sad, while all the school kids got to do things and play I had to sit in front of the mirror. I think the teacher was Mrs. Fox. I just don't know what to do anymore, but I never told a soul until I was 17, a run-away living at my grandmother's. Nobody wants to talk about nothing.

Then I got drunk bigtime, this time I flipped out in the streets, went to the hospital, got drunk with Chief of Police's daughter, Laurie McBee, told everybody, doctors, about everything. Told my parents, they didn't want to hear it, they wanted to keep it a secret. Then I went to a foster home with the Beacons', blew that. By then I was 17, been taking care of me and my brother and sister since we were little. I was living on the streets since I was fifteen, sleeping in school yard, in fields, going to school for the free lunch, the ——— liked me, smoke a bag of pot. Then I partied all night, drinking in the On Deck, Mid Town, Mahogany bar since 15 years old, filled out a report about the sexual abuse with Normal Mather a policeman.

Then a couple of months ago when I started to go straight, went to the police department in Newport and said I wanted something done about what happened to me. They wouldn't listen. They said, "What now?" I left. Then I heard this guy was in jail for this before, he had also done it to his sister in law, Cathy Bartel, nieces Katie, Priscilla, Brenda, and his own daughters Darlene and Lisa. Now his wife is babysitting for all these kids.

I know he's doing it, sexually abusing more kids. I called Welfare, I said, "They live at 606 Jebsons Lane, Middletown." They said, "Call such and such number." I called, talked to people, told them the whole story. They just said because it happened to you is no proof about these kids, so I guess I'll just take care of this motherfucker myself as soon as the time is right.

Nobody cares. I just can't stop remembering this. It was beat in your head, "You're no good, I hate you kids," over and over and over and over. After about 13 years, what would you think? I just don't know, [how to eat], what to dress in, what to say, when you are supposed to cry, when you are supposed to smile, when to laugh, how to act around people. I still suck my thumb, I wear clothes to bed so nobody gets me,

I dress like a tomboy so people think I'm tough, then they won't think I'm pretty, so why bother to like me, I fight all the time. Why should I listen to anybody, look where it got me, all fucked up.

The end is coming nearer and nearer. I wish I could have been a normal kid. I could have studied law enforcement, been a police officer or went to college, but I fucked up. I guess I'm no good just like my father said, I'll never amount to nothing more than a security guard or a military police in the National Guard, for which I'm not even MOS trained yet. This is as far or as close as I get to success.

As soon as I get up enough guts it'll be over. Soon. Very soon. PLEASE READ ALL THE PAPERS IN MY HOPE CHEST. The person who reads this, if you do publish this, please donate the rights and the money to abused children or Section 8 housing. I'm still working undercover for the cops, just busted Thomas Jefferies, 1101 Newport Green, been working undercover for police since I was 18, for 7 years now, but [now that I can't be a police officer, that's part] of my past. So I got fucked again and again.

I just want everybody to know I tried MY BEST but it just wasn't good enough. And so if I don't kill myself somebody will. I want the people who talked to me — well, I just want to say goodbye.

I just want everybody to know I tried my best but it just was not good enough. ☹️

Victimization and Homelessness

Cause and Effect

Pamela J. Fischer, Ph.D.

The literature on the contemporary homeless population is reviewed to examine the association of victimization with homelessness. Although few studies have specifically focused on victimization, findings derived from studies investigating pathways to homelessness, prevalence of health, mental health, and substance-use disorders, and demographic profiles and life histories suggest that victimization both causes homelessness and is an outcome of losing housing. Causal sequences ending in homelessness most frequently involve domestic violence, which mainly affects women, although other types of abuse may extrude individuals from their established housing. Once they become homeless, the risk of violence escalates for people living on the streets and in shelters. Perhaps the most unsettling findings from the research involve high rates of antecedent events, particularly abuse of children and disruption of families of origin, that appear to predispose individuals to homelessness. These data suggest that victimization is deeply rooted with long-lasting demoralizing consequences that burden affected individuals with excess prevalence of mental illness and related socially dysfunctional behavior that entrenches people in homelessness and may perpetuate patterns of abuse across generations. There is a crying need for early detection and targeted treatment to effect rehabilitation.

Victimization is so inextricably linked to homelessness that homelessness itself can be described as a type of victimization whereby the social structure bars an underclass from the protection enjoyed by the larger society. The advent of homelessness as well as its continuing experience have been defined as stressors that confer debilitating psychological trauma.¹ Homeless people have historically been victimized at greater rates than those with the physical and emotional resources to arm themselves against harsh treatment. For example, violence was described as endemic to skid rows, where intoxication produced both combativeness and stupor.² Although skid rows have all but disappeared from the contemporary scene, evidence gathered over the past decade documents that latter-day homeless people are no less subject to victimization than their predecessors.³ Moreover, an emerging literature suggests that victimization early in life establishes

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patterns of behavior that contribute to adult vulnerability to a host of adverse experiences, including homelessness.

Victimization appears to be both a cause and an effect of homelessness. For the purposes of this discussion, victimization, considered first as an antecedent to homelessness, is defined broadly to include adverse childhood conditions as well as specific abusive experiences reported by homeless adults. Victimization, defined more conventionally as experiencing criminal acts against a person and property, is examined as it occurs during homelessness.

Antecedent Victimization

While associations between childhood events and subsequent adult dysfunction, especially between child abuse and development of mental illness, have long been recognized,⁴ findings from a number of studies are beginning to point to childhood antecedents, especially abuse, as risk factors for homelessness as well.⁵ These recent data suggest that dysfunctional childhoods, including disruptions of families of origin, parental histories of problem behavior, and physical and sexual abuse, produce patterns of learned helplessness, disaffiliation, and cycles of abuse of which homelessness is one outcome. These long-standing patterns of socially dysfunctional behavior in turn increase barriers to re-entry into the social mainstream.

Indicators of Family Dysfunction during Childhood

There is mounting evidence that early experiences may increase later vulnerability. Disruption of families of origin through separation, divorce, or death of parents or by removal of children to extrafamilial settings, particularly institutional and foster care, can interrupt the child-rearing process at critical developmental points, so that emotional growth is arrested.⁶ Children raised in dysfunctional families, especially those whose parents are substance abusing or mentally ill, may not be nurtured sufficiently to form the basis of adult strengths and are more likely to be abused.⁷ Links have been identified between child abuse, specifically that which is sexual in nature, and development of personality disorders.⁸

The relation between out-of-home placement and chronic homelessness may reflect long-standing behavioral or emotional problems continued into adulthood, the debilitating effect of placement per se, or weakened family ties, all of which may increase individual vulnerability to homelessness and inability to manage independently. For example, 13 percent of a rural sample of homeless people in Ohio reported spending part of their childhood out of their parental home.⁹ Nearly two fifths of a Minneapolis sample of homeless adults had a history of placement as a child, which in turn was found to be associated with long-term homelessness.¹⁰ Studies in New York City have found that out-of-home placement such as foster care and problem behaviors were associated with mental illness in homeless men; for example, almost half of former psychiatric patients in a New York City shelter sample had been placed away from their families as children.¹¹ Moreover, it was also determined that mental patients who had been fostered or who had run away from home were more likely to report experiencing homelessness.¹² Nearly a third of homeless adults in Baltimore experienced dissolution of their childhood households through the separation or divorce of their parents, and nearly a quarter reported the death of a parent during their childhoods — in about 10 percent of cases, the mother had

deceased. More than half reported living apart from their parents for some period during their childhood. Although living with other relatives was the most common extrafamilial setting, 12 percent of men and 14 percent of women had lived in foster care or in an orphanage.¹³ In a study comparing homeless and housed poor families in Los Angeles, substantially higher rates of dissolution of families of origin through divorce or death as well as out-of-home placement were reported by the homeless mothers than by the housed mothers.¹⁴ In Kentucky, the rate of foster care placement among homeless adults was estimated to be more than four times greater than that of the general population.¹⁵ An elevated rate of family dysfunction is indicated in recent studies of homeless populations. Baltimore homeless adults were exposed as children to serious problems within their households. About half indicated that one or both of their parents had a "drinking problem." More than a third had parents who had been arrested, and about a quarter had mentally ill parents.¹⁶ In a Los Angeles study,¹⁷ nearly half of the homeless mothers compared with a third of the poor housed mothers reported parental alcohol or drug abuse.

Childhood Physical and Sexual Abuse

Evidence is emerging to link patterns of childhood abuse with homelessness. A number of studies have found high rates of childhood physical and sexual abuse in groups of homeless adults.¹⁸ Studies of homeless mothers and their children in Boston revealed that 42 percent of homeless mothers but only 5 percent of a comparison group of housed poor mothers had been abused as children, and twice as many of the homeless mothers (41%) as housed mothers (20%) had subsequently been battered in their adult relationships.¹⁹ Similar findings are reported for families in the Salvation Army Emergency Lodge in St. Louis.²⁰ Nearly a third of homeless adults in Baltimore suffered physical or sexual abuse as children or adolescents. Physical abuse was more frequently reported by both men and women than sexual abuse. However, homeless women were much more likely to report abuse histories in general, nearly twice as likely to have been physically abused, and more than three times as likely to have been sexually abused as homeless men. Furthermore, while abuse was confined to childhood in the main among men, women reported abuse persisting well into adolescence.²¹

A comparison of homeless applicants for emergency housing with domiciled recipients of public assistance in New York City found that 11 percent of the homeless and 7 percent of the housed individuals reported childhood physical abuse; 10 percent of the homeless but only 4 percent of the housed clients had been sexually abused before age eighteen. Furthermore, the homeless clients were more likely to experience abuse as adults (26% versus 16%).²² A survey of homeless adults in Manhattan shelters and streets also suggests association of early childhood trauma with subsequent homelessness: among 158 young (63% under 40) homeless persons, of whom about two-fifths were women, nearly a quarter had been abused as children; almost half of those reporting child abuse indicated that the abuse was sexual.²³

A more direct association between abuse and homelessness has been described among runaway and throwaway youth.²⁴ It is estimated nationally that more than a third of the youth who run away each year are fleeing from physical and/or sexual abuse in their homes; ironically, half turn to prostitution for survival.²⁵ Three fifths of San Francisco teenagers had been sexually abused prior to leaving home.²⁶ Nearly half of runaway and homeless youth in California shelters reported that they had

been abused or neglected by their primary caretakers.²⁷ Half of shelter-using homeless youth in New York reported parental abuse "such that they had repeatedly sustained bruises, cuts or welts or else had had to receive treatment in a hospital on at least one occasion."²⁸ Robertson²⁹ found that 24 percent of Hollywood street kids had become homeless at least once owing to physical abuse in the home and 8 percent owing to sexual abuse. Comparison of young runaway and nonrunaway users of Los Angeles outpatient medical clinics showed rates of physical and sexual abuse to be four to eight times higher among the runaways. Unlike findings of many other studies, sexual abuse (22%) was reported more often than physical abuse (16%).³⁰ These studies clearly establish abuse in the home as a significant contributing factor to homelessness among youth.

The consequences of being raised in disrupted or abusive families are far-reaching. In a study comparing homeless and housed men in Rochester, New York, it was concluded that "homeless persons are more likely than a comparable group of domiciled persons to retrospectively describe early relationships within the family as rejecting, emotionally impoverished, chaotic, and socially isolating" and point to the lack of maternal warmth as the critical factor in determining lack of success in adulthood.³¹ In a Manhattan sample, those with childhood trauma had experienced other serious problems while they were growing up; for example, 27 percent had trouble getting along with their parents; 35 percent frequently played hooky and failed to form expected social attachments as adults; 59 percent had never married; 43 percent had no contact with their relatives and 49 percent had no one to turn to for help; 51 percent had been homeless longer than one year.³²

The Baltimore study³³ also found that experience of disrupted and abusive households was correlated with childhood deviant behavior. Overall, the homeless adults reported individual examples of deviant behavior at greater rates, but also engaged in multiple forms of deviant behavior more frequently: about two fifths of the homeless adults reported two or more examples of deviant behavior, the most common being suspended or expelled from school for misbehaving and getting drunk or using drugs before the age of fifteen. Compared to a sample of housed adults, the homeless men and women were two to three times more likely to have run away from home and between three and four times more likely to behave violently and have experienced juvenile arrests. In most cases, childhood problems were also found to be correlated with elevated rates of adult dysfunction, including impaired social functioning and diminished social support, adult victimization, criminal behavior, and mental health problems, particularly substance abuse, depression, and personality disorders. In addition, homeless men and women who were the products of disrupted or abusive childhood homes were more likely to experience harsh conditions while homeless, including long-term, chronic homelessness, sleeping rough, scavenging for food, and so on.

Mothers who were physically and sexually abused by their parents frequently repeat the pattern of abuse in their own children. A recent study in Los Angeles showed that nearly a third of homeless mothers reported having been physically or sexually abused as children, and more than a quarter indicated that they themselves had been investigated by social services agencies for child abuse or neglect.³⁴ Bassuk and her colleagues were the first to note that homeless mothers were substantially more likely than housed mothers to have been abused as children as well as adults and nearly twice as likely to be currently under investigation for child abuse or

neglect, concluding that lifetime patterns of deprivation and violence foster a "newly emergent cycle of intergenerational homelessness [in which] it is not only the economics of poverty that has created the new phenomenon of homeless families, but the combined effects of poverty, violence, and profound deprivation on a person's development and self-esteem."³⁵

Victimization as a Precipitating Event

Although, as noted, there is growing evidence that early childhood experiences predispose abused individuals to becoming homeless as adults, the recent literature also demonstrates that adverse events occurring during adult life can precipitate homelessness. Homelessness becomes an outcome of victimization when abusive situations make once satisfactory living arrangements intolerable even in the face of no accessible safe alternative accommodations. People living on the social margins by virtue of poverty, disaffiliation, disability, and the like are especially vulnerable to such dissolutions of households. However, it is difficult to estimate the extent to which victimization in its myriad forms causes homelessness.

Relatively few surveys have queried homeless adults about the reason(s) they became homeless. Moreover, the evidence for direct links between an event definable as victimization and subsequent homelessness is limited by methodological problems, chiefly lack of standardized response categories and inability to assign priorities to multiple reasons, which reduce the generalizability of their findings. In many cases, patterns of victimization underlie reasons more readily reported. For example, a Baltimore man stated that he was homeless because he was unemployed, but further inquiry elicited the fact that he could not work because he had lost one eye and much of the sight in the remaining eye as a result of assault. Sampling procedures may also obscure the true prevalence of victimization through selection of individuals with lower probabilities of victimization-related homelessness. The most obvious effect is underestimating the causal role of domestic violence through exclusion of specialized facilities for battered women from most shelter surveys.³⁶

Perhaps as a consequence of these methodological problems, only a few studies cite domestic violence as the direct cause of homelessness.³⁷ However, it seems likely to be a hidden component when reasons for homelessness are given as family or personal crises.³⁸ Family conflict was reported to lead to homelessness for one quarter of a sample of homeless mentally ill adults surveyed in Milwaukee,³⁹ and nearly a third of rural homeless adults in Ohio.⁴⁰ Two fifths of the mothers in homeless families in Boston had been battered compared with one fifth of poor housed mothers. Moreover, the homeless mothers were more likely to escape abusive family situations by going to shelters for battered women while the housed mothers turned to close friends.⁴¹ Nearly two thirds of homeless mothers sampled in two New England cities reported some form of spousal physical abuse with nearly half experiencing the most severe form.⁴² In New York City, reports of domestic violence were substantially higher among homeless than housed families on public assistance.⁴³ In a comparison of homeless to housed low-income families in Los Angeles, the homeless mothers were more than twice as likely to report spousal abuse.⁴⁴

Despite these methodological problems, victimization, particularly domestic violence, is widely accepted as contributing to homelessness.⁴⁵ Women are more likely to report victimization as the cause of homelessness than men, who tend to identify reasons such as unemployment, alcohol problems, and jail release.⁴⁶

Certain forms of eviction leading to homelessness can be defined as victimization. In New York City, tenants of single-room-occupancy hotels — primarily poor elderly or disabled long-term residents — were found to be “standing in the way of the gentry.”⁴⁷ Conversion of these SRO hotels into more profitable condominiums depended on relocation of the existing tenants. Eviction was often accomplished through illegal tactics, including threats and harassment, arson, burglaries, and physical assault. One such removal campaign was likened to a “three-week reign of terror” that rendered many former tenants homeless.⁴⁸

People who are mentally ill are especially vulnerable to victimization as they are often disoriented, have little understanding of their rights, and frequently have diminished social support networks to mobilize in their defense. For these and other reasons, they may not be viewed as desirable tenants. All too often, caretakers have proved themselves more interested in siphoning off the entitlement benefits of their mentally ill charges than in providing a safe home. Abusive situations breed where supervision of residential facilities such as adult foster care homes is minimal. For example, a follow-up study of patients discharged from state mental hospitals in Michigan determined that 9 percent were currently homeless; 17 percent of these stated that abusive conditions, including rapes and beatings, had forced them from their postdischarge residences into homelessness.⁴⁹

Current Victimization

Victimization as a Consequence of Homelessness

Homelessness is a condition so fraught with peril that homeless adults experience victimization disproportionately compared with the housed population. The consequences may be more severe in homeless people who have fewer resources and skills to overcome the effects of trauma. Thus, victimization is associated with dysfunction in homeless people. For example, investigation of a sample of New York City public shelter users not only determined an association between experience of victimization and adverse health and mental health (including depression, psychoticism, suicidal ideation, and substance abuse), but also discovered a dose-response effect with increasing victimization episodes.⁵⁰

The homeless may be thought, to some extent, to be passive victims. Nevertheless, they are by no means unaware of the constant threat of violence inherent in street life. Homeless people frequently report safety to be a major concern.⁵¹ About as many of the homeless people surveyed in Manhattan shelters and streets said they were as afraid of being attacked in a shelter as on the street,⁵² and women who become homeless express feelings of fear of physical violence.⁵³ Levels of anxiety have been shown to be highest following the first episode of homelessness.⁵⁴ Indeed, despite high rates of victimization, only 20 percent of residents of New York City municipal shelters voiced fear of being hurt — less than rates previously found in general community samples, suggesting that as people remain homeless, they deny or become inured to the brutality of their environment.⁵⁵

Rates and types of injuries sustained by homeless populations are useful indicators of the extent of victimization. Trauma has been cited as one of the leading causes of death and disability among the contemporary homeless, many of whom suffer alarmingly high rates of repeat trauma and hospitalization.⁵⁶ In Anchorage, two thirds of a homeless sample had been assaulted, the majority on multiple occa-

sions; more than half required medical care with two fifths being hospitalized, indicating the level of violence experienced in these attacks.⁵⁷ About a quarter of all adult clients seen in the national Health Care for the Homeless clinics presented with trauma.⁵⁸ Nearly three quarters of homeless adults examined by physicians in California reported being victimized within the past year.⁵⁹ More than two thirds of a Baltimore clinical sample reported trauma as part of their medical histories.⁶⁰ In a medical records review of homeless persons treated at the Union Rescue Mission Infirmary in Nashville, one fifth of cases were discovered to be injury related.⁶¹

Surveys of homeless adults have produced substantial reports of recent victimization. Crimes perpetrated on homeless victims include offenses against property and against the person. High rates of victimization of homeless people have been reported in New York. One study found that half of the homeless had been physically assaulted,⁶² while a survey of 695 men residing in New York City public shelters reported that within the previous year the homeless men had fallen victim to one or more of four index crimes (simple and aggravated assaults, robbery and theft) between seven and forty times more often than the general population.⁶³ One fifth of a Baltimore shelter sample indicated they had been mugged within the previous three months.⁶⁴ More than a third of a Detroit shelter population had been a crime victim within the year; nearly three fifths had been victimized more than once, with one fifth reporting four or more occasions.⁶⁵ More than a fourth of shelter users in St. Louis had been beaten or robbed.⁶⁶ In Phoenix, nearly two fifths of homeless people surveyed in soup lines had been robbed, assaulted, raped, or harassed at least once during the previous six months.⁶⁷ In Los Angeles, more than a third of a homeless sample had been the victim of at least one crime during the previous six months, reporting an average of 2.24 episodes per person, with robbery, burglary, and assault being the most commonly reported offenses.⁶⁸ Another Los Angeles study indicated that more than half the homeless people on skid row were crime victims, half of these more than once, with the majority having been assaulted.⁶⁹

Some of the most poignant personal narratives of homeless people, particularly those voiced by women and adolescents, detail accounts of sexual assaults. One fifth of homeless adults surveyed in New York had been raped; three quarters of the rape victims were women, accounting for nearly two fifths of all of the homeless women in the sample.⁷⁰ One of every thirteen shelter users in St. Louis reported sexual abuse.⁷¹ In Los Angeles, 6 percent of a sample of homeless women had been raped in the previous six months.⁷² Review of medical records at the Sexual Trauma Service of San Francisco General Hospital⁷³ revealed that the treated incidence of sexual assault in homeless patients was estimated to be twenty times greater than in the general population. The majority of homeless victims of sexual assault were women, half of whom sustained injuries ranging from minor abrasions to major trauma, including skull fracture; all victims were judged to have experienced some degree of psychological trauma in addition. Moreover, 12 percent of the homeless patients were repeat victims.

It is obvious that life on the streets invites violence, but ironic that shelters themselves do not always offer safe havens. Not only is theft rife in shelters, as even the best-staffed facilities can provide little real security,⁷⁴ but violence can quickly erupt in a volatile mix of residents, some recently released from jail, prison, or mental hospital. Lumsden⁷⁵ suggests that about 6 percent of clients of Dallas shelters could be classified as "troublemakers" — a group of violence-prone young men who victimize

the other shelter users. The proportion of men barred temporarily or permanently from the largest mission in Baltimore for causing problems, including violent behavior, arson, and stealing, increased from 5 percent in 1981 to 14 percent in 1986.⁷⁶ As the shelter-using population has become younger and more violent, the threat of physical harm has escalated to the point where the most vulnerable homeless — such as the elderly — have been “crowded out” of the shelters.⁷⁷ Moreover, both intimidation and physical abuse, including murder of clients, have been attributed to the staff of some of the immense public shelters in New York City.⁷⁸

Often homeless people do not seek redress from the law enforcement system, having observed that police are less responsive to the needs of the homeless than of the general population;⁷⁹ the more serious or violent crimes are more likely to be reported.⁸⁰ Another reason that homeless persons fail to report crimes is that the police may be regarded as enemies rather than champions: reports of police harassment are rife.⁸¹

Risk of Victimization

Studies that have compared rates of victimization among homeless samples and the general population have documented substantially higher rates among homeless people.⁸² However, risk of victimization is not uniformly distributed among the homeless population. Findings from the literature of the past decade demonstrate that vulnerability attracts victimization. Thus, those homeless individuals who offer least resistance by virtue of physical disabilities, intoxication, advanced age, disorientation, and high visibility are most readily victimized.⁸³

Gender differences in victimization experience have been noted. Although women express greater levels of fear of being hurt, higher rates of victimization, contrary to expectations, are typically reported by men. However, women are at greater risk of attack with sexual intent.⁸⁴ Among a sample of New York City public shelter users, rates of victimization among men exceeded those among women in all categories except sexual assault and beatings.⁸⁵ Much of the difference in rates probably derives from greater exposure to risk on the part of men. Higher rates of recent victimization in men compared with women in a Baltimore sample were attributed to a higher index of risk conferred by their greater likelihood of sleeping “rough” and being intoxicated.⁸⁶ In California,⁸⁷ three quarters of street people compared with about half of shelter users reported victimization. Homeless alcohol and drug users report higher rates of victimization and injury, and substance-use disorders, particularly alcoholism, are substantially higher in homeless men.⁸⁸ The fact that rates of arrest are also substantially higher among men may elevate their injury rates, as there is evidence that criminal activity increases risk of victimization. Homeless people in Baltimore with prior arrest histories were nearly twice as likely to have been crime victims and almost three times more likely to have been raped.⁸⁹ High rates of victimization, particularly sexual assault, have also been reported among homeless youth, whose risk status is enhanced through high rates of exposure to the streets, alcohol and drug abuse, and prostitution.⁹⁰

Homeless persons with obvious disabilities, not only physical but including mental retardation and mental illness — particularly the “space cases” — also attract undue attention from the street predators.⁹¹ The chronically mentally ill among the Los Angeles homeless surveyed were more likely to have been victimized within the previous year — particularly being assaulted — and to report more than one type of vic-

timization.⁹² Brickner⁹³ suggests that “bag-ladies on the street with massively swollen legs wrapped in rags are . . . more easily victimized and subject to assault.” Rates of assault and robbery in New York homeless men were highest among those who reported poor health and physical disabilities.⁹⁴

The realization of the central role of victimization in creating and sustaining homelessness has come relatively late to investigators, arising mostly from incidental findings of early surveys. To date, few studies have specifically focused on victimization.⁹⁵ The extant evidence for the pervasiveness of victimization, besides being fragmentary, is plagued by methodological problems. Chief among these is that while these early descriptive studies established associations between victimization and homelessness, causal sequences could only be inferred as the bulk of studies have been cross sectional. In addition, it is difficult to generalize from early findings because lack of standardization of definitions and sampling methods have made it difficult to compare data across studies.

General consensus has been achieved in recognizing posthomelessness victimization. Violence perpetrated against homeless people has been historically well documented, particularly on skid rows,⁹⁶ so that findings of elevated rates of injury and trauma in the contemporary homeless population were not surprising. Nevertheless, the magnitude of the trauma sustained, its distribution among the population, and its long-lasting effects in terms of costs of treatment, demoralization, and entrenchment of homelessness are startling and not yet fully understood.

Next to surface in early studies examining pathways to homelessness was the suspicion that homelessness might result directly from certain forms of victimization — principally domestic violence ousting women from their homes — or that victimization might underlie reasons for homelessness such as job loss or substance abuse. Perhaps the least suspected effect of victimization was suggested by early, almost serendipitous findings of what appeared to be excessively high rates of various indicators of early childhood dysfunction, especially of foster care placement and physical and sexual abuse. Links to parallel investigations among mentally ill populations suggested that such adverse conditions of childhood might predispose affected individuals to subsequent adult problems, including patterns of learned helplessness leading to continued victimization and difficulty coping with adult responsibilities, disaffiliation, mental disorders including depression and personality disorders, substance abuse, and continuation of the cycle of abuse in succeeding generations.⁹⁷ By extension, it seemed likely that the pattern of learned helplessness engendered by early abuse might also lead to homelessness.⁹⁸

Victimization of people in shelters and exposed on the streets has been considered to be an outcome of homelessness, perhaps the extreme indignity that the homeless are made to suffer. After all, if violence is endemic among the underclass in inner cities, homeless people experience the worst of it by virtue of having a foothold on the lowest rung of the social ladder.⁹⁹ The effect of such violence goes beyond the inflicting of physical suffering and/or permanent disability to psychological demoralization and the ever present fear and distrust of others frequently reported by homeless populations.

The most obvious impact of victimization bred by homelessness is on the public health: the literature abounds with reports of trauma in homeless populations which far exceed that experienced by the general population. The high trauma rates

coupled with a pattern of health care utilization heavily dependent upon emergency and inpatient care suggest high-ticket care.¹⁰⁰ Although seldom reported, it is likely that substantial rehabilitation of injured individuals may be needed to prevent or ameliorate permanent disability. It is not known how rehabilitation contributes to overall health costs or to what extent its lack entrenches homelessness by impeding subsequent employment and fostering demoralization. It also appears likely that people suffering physical and emotional pain turn to alcohol and drug use for their anodyne effects.¹⁰¹

Studies of the costs to the health care and other human services systems incurred through victimization of homeless people need to be undertaken. Effective treatment of traumatic injuries, including physical and occupational rehabilitation, may be critical in returning individuals to the mainstream. In addition to treatment resources, prevention is critical, particularly since the literature demonstrates an unequal distribution of risk within the homeless population, making it possible to target the most vulnerable members. It is likely that the benefits of preventive measures to ensure adequate protection of high-risk individuals, from more effective policing to provision of safe housing, including residential treatment facilities for the mentally ill and substance-abusing homeless, would far outweigh short-term costs.

Although overall rates of victimization are high in samples of homeless people, individual risk appears to vary according to demographic and psychosocial characteristics. For example, the duration and circumstances of homelessness appear to increase risk of victimization so that those who are long-term or chronically homeless and spend substantial periods of time in unprotected situations, namely, unsheltered, escalate their risk. Additionally, intoxicated, disoriented, and feeble persons also risk victimization disproportionately. With some notable exceptions, men incur victimization at greater rates than women because elevated risk attaches to them from their relatively higher prevalence of substance abuse, street dwelling, participation in criminal activities and histories of incarceration, and perhaps, higher levels of aggression. Consequently, although men may be forced into homelessness through victimization, for example, abuse of residents in boardinghouses or adult foster care settings for the mentally ill or developmentally disabled, they are considerably more likely to become victimized as a consequence of homelessness. The chief consequences of this variant of victimization probably relate to compromised physical health and emotional problems associated with demoralization and depression, which may impose significant barriers to rehabilitation. Women exceed men in experience of sexual abuse during homelessness as well as antecedent events, particularly domestic violence but probably childhood sexual abuse as well. Thus, victimization may have a more powerful causal effect on women than on men. Patterns of victimization observed in women foster dependence and intergenerational cycles of violence.

Targeted prevention strategies should take these gender differences into account. Interventions aimed at men, for example, should attempt to improve the safety of shelters and devise secure havens for those who avoid shelters or are denied access because they are intoxicated or exhibiting florid psychiatric symptoms. Interventions aimed at reducing aggressive responses, similar to those offered to batterers, might foster skills needed by young homeless men to live in communal shelters, and eventually in mainstream settings, without erupting into violence. Interventions targeted to women, however, might better be offered to women at risk for homelessness in

addition to those who are already homeless to bolster self-esteem and prevent inter-generational cycles of violence. Bassuk¹⁰² documents the critical need to intervene in the vicious cycle of abuse and neglect that passes between victim-mothers who in turn victimize their children to prevent the pattern of impairment and instability that can lead to homelessness from becoming entrenched through generations.

While it is clear that certain patterns of victimization are caused or intensified by homelessness, there is a lack of longitudinal data to describe the role it plays in causing or maintaining homelessness in individuals. Victimization is blamed for precipitating people into a state of homelessness, domestic violence being most frequently reported. While men are affected, women appear to be the principal victims among the homeless. However, evidence of the precipitating effect of victimization on other groups — runaway youth, children, elderly — is beginning to emerge.¹⁰³

Perhaps the most striking finding emerging from recent research is the high rates of childhood dysfunction among homeless adults. There is some evidence that homeless men and women have similar experiences according to some indexes of childhood dysfunction, chiefly related to disrupted families of origin and physical abuse. Homeless women report higher rates of sexual abuse and indicate it to be of longer duration than homeless men do. In most studies, adult dysfunctional behavior has been correlated with childhood dysfunction, suggesting that substantial adult risk attaches to childhood adversity. For example, these data suggest that people abused as children develop psychiatric disorders, including depression and personality disorders, and continue to be victimized as adults. They are also more apt to exhibit learned patterns of physical and sexual abuse in their adult relationships as mates and parents.

However, it is important to note that the homeless in general can be described as such a high-deficit group in terms of their mental and physical health, social relations, vocational skills, and so forth, that associations between childhood factors and adult circumstances can be blunted. Risk factors may thus be more easily identified in comparison populations in which contrasts are more sharply defined. Findings from studies comparing homeless and housed samples suggest that childhood adversity acts as a powerful agent for downward drift. The reasons that individuals accumulate in disadvantaged populations such as the impoverished and homeless are probably rooted in failures of children raised in dysfunctional families to learn skills that promote success in adulthood — learned helplessness.

These data are far from conclusive regarding childhood antecedents to either homelessness or mental illness. Much more work needs to be undertaken to determine risk factors and interactions between them. Nevertheless, these findings are provocative and critical to pursue in terms of developing interventions aimed at two important groups. First, identification of areas of vulnerability in mentally ill populations may prevent homelessness. Bolstering the ability of people to develop supportive social networks may have a protective effect. Second, scores on indexes of childhood dysfunction might be used to specify types of interventions with high likelihood of success for returning individuals to mainstream life. This could have particular importance in breaking the “cycle of homelessness” described by Ellen Bassuk and her colleagues in Boston,¹⁰⁴ where women abused as children must be retrained to break the pattern of abuse vis-à-vis their children and stop being victimized in their adult relationships. Links between adverse early life events and adult dysfunction point to the importance of early intervention to prevent subsequent

difficulties as well as areas for emphasis in treatment of homeless and/or mentally ill adults.

To reiterate, victimization appears to be embedded in homelessness at least in its contemporary form, if not throughout history. It arises from patterns of behavior deeply rooted in virtually every aspect of social life, but is perhaps most visible in disadvantaged populations among which homeless people fare worst. Victimization is pervasive and its effects devastating and long lasting, resulting in culturally molded patterns of behavior transmitted generationally that are extremely difficult to reverse. Although homelessness itself fosters violence, victimization has been shown to cause homelessness directly through events that propel individuals onto the street, as well as more insidiously. Chains of events beginning in childhood render individuals unable to cope with demands of adult life, thus predisposing them to becoming and remaining homeless.

In terms of the policy implications of associations between victimization and homelessness, it will first be necessary to devote resources sufficient to study this relationship in greater detail through rigorous research methods including longitudinal study designs, comparable sampling plans, and standardized response categories. Comparison groups are necessary to estimate risk of antecedent events.

Victimization must be viewed with a systemic perspective in order to appreciate interrelationships of problems as well as services. It is important to forge institutional linkages between systems not heretofore viewed as closely related — education and day care, health and mental health, substance-abuse treatment, criminal justice, social and protective services, shelter providers, and so forth. There is a great deal of fragmentation between social services agencies, health and mental health treatment providers, schools, and battered women's shelters, with no well-established system of early detection and treatment of abuse.¹⁰⁵ Moreover, issues of abuse and other forms of childhood dysfunction are seldom elicited in treatment or featured in therapy among mentally ill patients, and more infrequently still among homeless populations, although homeless women might benefit greatly from resolving these issues and stopping the cycle of abuse.¹⁰⁶ Greater efforts should also be made toward retention of custody of children in homeless families in view of the detrimental effects of family disruptions.¹⁰⁷ Current models of case management should be altered to accommodate victimization-engendered problems in homeless populations.

Finally, society must make a real commitment of will as well as resources to stop the escalating level of violence that pervades modern life to the great detriment of the most vulnerable members of society — children, women, physically disabled, mentally ill, and poor people. Interventions, seemingly costly, will in the long run prevent great suffering by avoiding heavy cost shifts to alternate systems of care, such as emergency rooms and mental and penal institutions. ■

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Classification and Its Risks

How Psychiatric Status Contributes to Homelessness Policy

Anne M. Lovell

This article examines the extent to which psychiatric classification in public policy research contributes to the equation of homelessness and mental illness. Surveys that measure psychiatric status of homeless persons are reviewed to understand whether they contribute to biased rates of mental illness among homeless persons. The relationship between psychiatric classification and the concept of need is examined and alternatives to current classification are proposed. Classification is discussed particularly in relation to policies of segmentation for "single" homeless adults.

Homeless? I guess that's the category that's left over in this age of specialization.

— Resident of a municipal women's shelter, Queens, New York, 1987

The people are absolutely incapable of classifying themselves without assistance.

— G.V. Maxwell, a colonial administrator in Fiji, 1915

Injurious social phenomena exist and are even noticed without being perceived as a social problems.¹ In fact, some may even be periodically "rediscovered."² Yet once they emerge as a public problem to be managed, classification becomes an issue. For within the rationality of the modern welfare state (and of earlier systems of charity), redistributive politics require some system of classification to indicate eligibility for such resources as cash payments, privileges, access to services and goods. This is the meritocratic process also known as separating the "deserving" from the "undeserving" poor.

By now, the phenomenon of thousands of homeless men, women, and children in the United States has gained legitimacy as a social problem.³ And as the numbers of persons without stable, permanent places to live have risen, so have the classifications that separate them multiplied. In fact, concern with establishing whether the magnitude of homelessness justifies a federal response has given way to "intelligent segmentation"⁴ — the classification of homeless individuals into policy-relevant groups, each of which calls for a specific service response.

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New York City already provides a window on this process: more than any other American city, it has been forced, in large part through adversarial legal processes, to provide an extensive, if ad hoc, system of social and housing services for homeless persons. One response to the increase in “single” adults⁵ seeking shelter — New York City’s municipal shelters have increased from three a decade ago to between twenty and twenty-five today, serving up to seven thousand residents nightly — has been to further classify shelter residents. Formally and informally, shelters are divided along lines of age, employability, sexual preference, disability, and so forth. Recommendations of a recent mayoral commission, aiming to revamp the city’s costly shelter policy, in fact reinforced the already existing practice of segmentation by recommending that the large municipal shelters be replaced by smaller ones, targeting specific “problem” groups (substance users, the able unemployed, the mentally ill, and so forth).⁶ While the importance of services cannot be overemphasized, segmentation policy’s emphasis on targeting specific problems and refining categories among the homeless fails to address the underlying causes of the homelessness itself. As we shall see, this classificatory practice tends to identify causes of homelessness as well as the needs it generates with a single, salient characteristic.

Classification can thus be thought of as characterizing a second stage in the emergence of homelessness as a social problem. The first stage was exemplified by the “numbers game,” in which advocates and conservative policymakers struggled over the recognition of homelessness as a legitimate public problem. The second stage, not unrelated to the earlier mobilization of advocates, is the plan of action for managing the problem; here the larger tensions of the welfare state, between meeting need on the one hand and disciplining, deterring, and (more recently) cutting back costs, are expressed. The current refinement of categories of homelessness represents attempts to provide categorical resolutions to these welfare dilemmas.

In shaping homelessness as a major social problem of the 1980s and 1990s, both public policy and popular opinion often identify the phenomenon with mental illness. Unquestionably, in the race for scarce housing, extremely vulnerable persons who suffer from ongoing psychiatric disorders have fallen through the cracks more easily than those who can better negotiate access to resources. Thus, they appear in disproportionate numbers on the streets and in shelters. However, the shift in the hegemonic view of homeless persons as shiftless, often intoxicated, vagrants (the stereotype of post-World War II) to disorderly mentally ill cannot be explained solely by “facts” and the characteristics of homeless persons themselves.

Some psychiatrists were aware of the appearance of psychiatrically disturbed individuals among homeless persons as far back as the seventies.⁷ For years, the prototypical homeless person was the shopping bag lady, whose image of physical deterioration and bizarre behavior blended with a folk notion of mental illness. Subsequently, the homeless label came to group many types of poverty, whose common denominator was a lack of housing. Yet despite clear evidence of an association between the rise of homelessness and such economic changes as the restructuring of the job market and the disappearance of low-income housing,⁸ popular representations often identify homelessness with mental illness.⁹ While homeless families dominate media attention, homelessness as a social problem continues to be constructed around the idea of the “impaired capacity” of individuals, with mental illness the central characteristic.¹⁰ Among homeless who are mentally ill, it is often the illness that is considered the cause of homelessness.¹¹

This article, organized in three parts, is concerned with the extent to which psychiatric classification in public policy research contributes to the equation of homelessness and mental illness. The first part discusses how studies that assess psychiatric status of homeless persons contribute to biased rates of mental illness among homeless persons. Next, the relationship between psychiatric classification and the concept of need in public policy research about homelessness is examined. Finally, from an applied research perspective, alternatives to classification by psychiatric status are suggested. Similar issues of classification apply to substance abuse and other characteristics being targeted by research and policy on homelessness, and to other groups, such as homeless families. However, this article focuses on mental illness and “single” homeless adults.

Does Classification Overdetermine Mental Illness?

Central to numerous government-funded surveys that count and characterize homeless persons in the United States has been the assessment of psychiatric disorders. Despite the range in the rates they report for mental illness, these studies present clear evidence of considerable mental illness among homeless persons. Yet problems in the way assessments are carried out have allowed generalizing from those studies that show *high* rates of disorder to all homeless. And they have lent themselves to the blurring of distinctions between homeless persons with severe psychiatric disorders and those who are either temporarily distressed or psychologically “well.”

In the last decade of research, sociologists and mental health professionals alike, struggling to establish a “true” rate of mental illness among homeless populations, used standards quite different from those accepted as scientifically solid in current psychiatric and epidemiological research. For example, in the absence of mental health assessments generated through the use of standardized instruments, they often relied on records or the expert judgment of mental health workers, but without the explicit, or standard, data-collection procedures, much like earlier generations of now critiqued psychiatric epidemiology investigations.¹²

A good example of the standards these researchers and professionals used is found in a series of published exchanges concerning whether or not mental illness among the homeless is a myth. Snow et al. first published an article estimating an extremely low rate among the homeless of Austin, Texas.¹³ They defined people as mentally ill if they met two of three criteria for mental illness: (1) a history of psychiatric hospitalization, (2) reports by other homeless of extremely bizarre or “crazy” behavior, and (3) observation by the fieldworker of behavior grossly incongruent with context. (The second and third criteria have grounding in an interactionist approach to the definition of mental illness, found in anthropology and sociology).¹⁴ Another sociologist, Wright, correctly asserted that the Texas rates are probably lower boundaries.¹⁵ But along with his critique, he produced another measure of mental illness that could be considered weak: an assessment based on one contact by a trained (but unspecified) health professional. A third group of social scientists¹⁶ then critiqued Wright’s self-selected sample — homeless persons who come to health clinics — but also pointed out that consensus on mental illness certainly does not exist even among mental health specialists and researchers, a fact that can be gleaned from the psychiatric literature on diagnoses that precedes every revision of the American Psychiatric Association diagnostic manual.¹⁷

Among the other major types of psychiatric status indicators commonly employed in studies of the past decade have been (1) scores on scales that measures symptoms and/or impairment in functioning, (2) diagnoses generated from clinical evaluations by mental health professionals, and (3) diagnoses generated from standardized clinical instruments. A review of these studies¹⁸ suggests at least three problems of assessment that contribute to erroneous conclusions about homelessness and psychiatric status. These methods include how the homeless group was sampled and where the study took place (site); the diachronic dimensions of psychiatric conditions; and environmental contamination of measures.

In general, studies that used small, nonrandom samples at specific sites, such as shelters for persons with psychiatric problems, reported higher rates of psychiatric disorder. Service sites and other locales differ as to who frequent or use them, and this "selection factor" in turn affects reported rates of mental illness. Examination of who uses certain shelters or is to be found at a given site may explain why rates differ. For example, schizophrenia is reported to be almost five times as high among men¹⁹ and older female shelter residents²⁰ than among young homeless mothers.²¹

Only a truly representative sample could overcome these problems of selection. But representativeness of all types of homeless persons is difficult to achieve, given the high mobility of many homeless, the difficulties in identifying "street" dwellers, and the illusion created by one-day (or -night) cross-sectional "snapshots," and so forth.²² For example, one study came close to being representative of all homeless, sheltered and unsheltered, in a given city. However, not all shelters agreed to participate in this survey.²³ Furthermore, the methodology for contacting nonsheltered persons consisted of targeting blocks designated by police and service providers and approaching homeless persons in the dead of night, and in the company of police officers. This methodology has been critiqued as undercounting the nonsheltered homeless, especially those who might have been scared off by police or slept in areas not identified to the researchers.²⁴

Other large surveys reach but a segment of the homeless population. The surveys of New York City's municipal shelters exclude, by definition, persons staying in family shelters, private shelters, or on the streets at the time of interview.²⁵ A major Los Angeles study was limited to that city's skid row,²⁶ another to selected sites in two areas of Los Angeles county.²⁷

The problem with biases due to site or sampling difference lies as much in the interpretation of the study results as in the methodology chosen by the researcher. As noted above, findings from sites with high rates of disorder have tended to fuel the media. For example, a few years ago a *New York Times* article cited a local study that showed most homeless people to be severely mentally ill. It did not point out that the site of the study, a psychiatric emergency room,²⁸ would obviously draw only people with psychiatric emergencies.

The second problem of assessment stems from the use of symptom scales and psychiatric treatment histories as indicators of mental illness. When scales that measure symptoms or distress have been used instead of psychiatric diagnoses, the rates of distress turn out to be very high.²⁹ Almost half the homeless persons across all studies of the last decade score above cutoff points for "normal" populations, though the sites are different and the instruments used vary.

One reason for such high rates involves temporality. Whereas diagnostic systems generally build in specific duration criteria — for example, according to criteria in

the official manual of the American Psychiatric Association, *DSM III-R*,³⁰ the symptoms of schizophrenia must have lasted at least six months for a diagnosis to be made — symptom scales are often anchored on the past week or some unspecified “present.” This creates confusion as to exactly what is being measured. Many scales are measuring something very nonspecific and transitory, such as distress or demoralization. This interpretation contrasts with the conclusion, based on scores from these scales, that almost half of homeless persons are mentally ill.

Demoralization, “a condition that is likely to be experienced in association with a variety of problems . . . and perhaps conditions of social marginality as experienced by minority groups and persons such as housewives and the poor whose social positions block them from mainstream strivings”³¹ can affect all sorts of people in the same situation — flood victims, residents of poor neighborhoods, and certainly men and women living in crowded, unsafe shelters. Like distress, demoralization is affected by the dimension of time in two ways. First, the symptoms can be reactive, disappearing once someone leaves the noxious environment. Second, because the scales themselves use differing, usually short time frames (for example, the last week, for the widely used Center for Epidemiological Studies — Depression Scale, or CES-D), ongoing symptoms cannot be differentiated from transient ones.

The CES-D illustrates this problem of cross-sectional versus longitudinal time frames. The CES-D score above which subjects are considered to be “clinically” depressed was established through epidemiological and psychiatric research because it distinguished persons who were somewhat distressed from those who were “normal.” It may be that when applied to homeless persons, high scores on these scales measure a reaction to the homeless situation more often than symptoms of an illness. For example, the 1985 survey of New York City’s municipal shelters showed that first-time users of the shelter, on the average, had higher CES-D scores than men who had been in the shelters for long periods of time.³² This could be interpreted in a couple of ways. First-timers could still be suffering acute distress from recently becoming homeless. (This interpretation is consistent with the literature on the psychological consequences of losing a home or moving.)³³ Alternately, they could be in “shelter shock” from the first encounter with the violent and unhealthy environment of a city shelter. Other researchers who found very high CES-D scores among the homeless have also interpreted these scores as signs of demoralization.³⁴ Of course, in all these studies, persons with severe psychiatric disorders may also score high on the CES-D.

Another temporal issue is the assumption that past characteristics are present. This can be a problem when information on treatment history is used. Only one indicator of psychiatric status, history of psychiatric hospitalization, is comparable across studies, although it is probably underreported by homeless persons, especially when they fear coercion into treatment. However, having been in treatment in the past is not an indication of whether one is currently disturbed. An Ohio survey illustrated this quite well.³⁵ One thousand homeless persons from twenty randomly selected counties were interviewed. Almost half of those who had been hospitalized in the past did not report experiencing *any* psychiatric symptoms at the time of interview.³⁶ Hospitalization history does not tell us much about *current* psychiatric status.

The last assessment problem concerns both diagnoses and symptoms. This confounding has been termed “the contaminating effects of external contingencies.”³⁷ The concept can be applied to conditions of homelessness that may inflate rates of

disorder. Some aspects of a homeless person's life, like not having a regular place to live or not holding a regular job, are part of the official psychiatric definition of certain diagnoses such as antisocial personality disorder. Thus, simply being homeless could increase the likelihood of receiving a diagnosis of a psychiatric disorder.

For example, the *DSM III-R* criteria for antisocial personality disorder could easily describe a lifestyle that represents structured arrangements in a context of economic and other constraints, rather than reflecting the conscious violation of others' rights. The criteria which must have been met in adulthood also appear class bound or at least partly environmentally determined. In fact, they describe events or reactions to conditions of the lives of many homeless — for example, significant unemployment, repeated thefts, irritability or aggressiveness (anger), failure to plan ahead “as indicated by travelling from place to place without a prearranged job or clear goal for the period of travel or clear idea about when the travel could terminate or lack of a fixed address for a month or more.”³⁸

The hypothesis that rates of antisocial personality disorder are inflated by environmental factors in the lives of homeless persons was tested empirically in the Los Angeles skid row study.³⁹ When criteria that described characteristics more common among the homeless than among a nonhomeless comparison group — not having a regular place to live, not working for six months or more, having held more than three jobs in the past five years — were eliminated from the definition, the percentage of homeless with antisocial personality disorder decreased. Lifetime prevalence of antisocial personality disorder dropped by one-third, from 31 to 21 percent. Current prevalence also dropped one-third, from 25 to 17 percent.

A second example of such environmental contamination concerns both diagnosis of depressive disorders and symptoms of depression. Having sleep disorders, not being able to concentrate, and losing weight are symptoms of major depressive disorders. They are also common among people who must sleep in dangerous or uncomfortable places and depend on scavenging or handouts for food. The Los Angeles study just cited actually found that these symptoms were not more common among depressed homeless than in domiciled comparison groups. In another study, however, in a factor analysis of the symptom scales administered to homeless persons with serious psychiatric disorders, symptoms of dysphoria (feeling blue, depressed) did not correlate with sleep and appetite disturbances.⁴⁰ A correlation was expected because the latter symptoms constitute a dimension of the diagnosis of major depression in various nosological systems.

In this section, it has been argued that surveys measuring psychiatric status among the homeless tend to inflate rates of mental illness among them. The way study subjects are sampled and the sites where the study is carried out create differences in rates. The validity of the measures — whether they are measuring what researchers intend them to measure — are affected by both temporality and environmental contingencies. Is the validity problem inherent in the research, or does it lie in the process by which nonresearchers interpret results? In some cases, researchers have fallen prey to generalizing findings based on studies of specific sites to most homeless people. Other researchers are more conservative in interpreting their measures. Still others use a combination of measures to indicate psychiatric status, such as a composite of symptom scale scores, interviewer ratings, and psychiatric hospital history. However, media reports tend to concentrate on high rates with little interpreta-

tion. In this perhaps unintended sense, psychiatric classification in surveys of the mentally ill overdetermines mental illness among the homeless.

Psychiatric Status as a Construction of Need

Earlier, it was suggested that classification takes on importance when the emergence of a social problem reaches the stage where discussion, advocacy, and other tactics force action. The action can be seen in the ensemble of policies, plans, and programs that develop around homelessness. How does psychiatric classification of homeless persons affect these actions?

A rational assumption might be that such classification provides a database for active policy. In this process, psychiatric status comes to stand for the need for mental health services. Then, if psychiatric classification has inflated rates of psychiatric disorder among the homeless, public policy must concern itself with managing large numbers of psychiatrically disabled persons. This view can be challenged on both an empirical and a conceptual basis.

Mental health policy for homeless persons in New York State over the past decade and a half belies a one-to-one relationship between psychiatric status as an indicator of need and the development and provision of services. Hopper has shown how data concerning the presence of psychiatrically disturbed individuals among homeless persons existed prior to any official responses to the problem.⁴¹ In the early 1980s, although State Office of Mental Health bulletins reported a high number of shelter residents assessed as needing mental health services, state officials publicly disavowed high rates of psychiatric disorders among the homeless.⁴² As Hopper explains, any acceptance of such a rate would have been tantamount to acknowledging the failure of deinstitutionalization. When a state-commissioned random study of shelter residents found 33 percent to have histories of previous psychiatric hospitalization, it argued that, given the time lag between change in hospital policy and the appearance of homelessness, deinstitutionalization could not explain the presence of mentally ill homeless persons.⁴³ A similar argument was presented in studies commissioned by state offices of mental health in Ohio⁴⁴ and Michigan.⁴⁵ In New York, the Office of Mental Health also refused a primary responsibility for basic material needs of homeless mentally ill in its 1981 five-year plan, although subsequently it went on to provide some housing for them.⁴⁶

In the late 1980s, New York City's roundup of mentally ill homeless from the streets provided another illustration of the distance between research findings and policy. This action, the so-called Koch Plan, was carried forth even though, from the very beginning, city as well as state mental health officials declared that the mental health system did not have the beds to accommodate more patients. In fact, the heart of the plan — an extension of the state mental hygiene law to allow, as grounds for involuntary hospitalization, behavior patterns suggesting that persons might harm themselves in a foreseeable future — was articulated by the mayor as early as 1981, when the city administration attempted to absolve itself of responsibility for sheltering the homeless. The plan itself affected only a small number of people and is focused on emergency and acute services, not long-term supports. The plan also aimed to pressure the state into providing more facilities for the mentally ill homeless, perpetuating the old state-city struggle over responsibility for the homeless that began in 1980.⁴⁷

If a major goal lay behind the policy, it may have been linked more to the economics of postindustrial cities than to psychiatric problems conceived of as needs. The plan targeted Manhattan from 110th Street on the Upper West Side and 96th Street on the Upper East Side to downtown Manhattan, although there is no hard evidence that the most severely mentally ill frequent only those areas. These are, however, prime areas for real estate and tourism. The tension between ejecting disturbing individuals from public space, or treatment for the sake of "aesthetics," and legitimate treatment for a psychiatric disorder runs through the court case of Joyce Brown, the homeless woman forcibly removed, under the policy, from the East Side sidewalk where she resided. Alternately described as dirty, disheveled, malodorous, delusional, acutely psychotic, possibly suffering from lupus cerebritis (a degenerative disease that can affect brain functioning), possibly suffering from schizophrenia or a severe affective disorder, and, in her words, "a professional street person, though not a career street person,"⁴⁸ Brown's psychiatric classification was never clear. If she is a symbol of the policy by which she was hospitalized involuntarily, then her case suggests that psychiatric classification bears little direct relation to policy. The "aesthetic" approach, a reflection of land value and transformation,⁴⁹ characterized earlier practices of hospitalizing homeless mentally ill individuals.⁵⁰ It was also a major reason for funding many skid row studies in the fifties and sixties. At that time, though, alcoholism, not mental illness, provided a rationale for treatment, which often amounted to removal of skid row men from urban renewal areas and central business districts.

In social policy research, the concept of need takes on a universal quality, as if it were a clear, objective phenomenon that could be attributed to the individual recipient or potential recipient of services. An alternative approach interprets need as a socially constructed reality that, in policy research, serves as a guide for designing and planning services and for the functioning of organization. In his analysis of British social welfare research, which is applicable to the United States as well, Smith identified numerous variables that are represented by "needs," such as agency-determined eligibility for resources, expressed need of individuals for a resource, needs assessed by researchers.⁵¹ What concept then, lies behind using mental health status as a major variable in surveys of the homeless?

The studies reviewed earlier suggest a multiplicity of constructed needs, as we will see. In fact, the needs assumed by using rates of psychiatric disorder or distress do not coincide with the needs expressed by homeless persons themselves. By now, enough surveys have established the consistent finding that homeless persons do not necessarily express a need for the mental health resources service providers and researchers assess them as needing. They also order their needs quite differently from the way professionals do.

The 1985 survey of New York City municipal shelters illustrates this point.⁵² Both clients and interviewers were asked to rate needs for services in twenty different areas of living. The largest discrepancy between client and interviewer judgment was in need for help with health and emotional problems. Interviewers judged that 52 percent of the clients needed these services, yet less than half (23%) of the clients reported that this type of service could improve their quality of life. Other large discrepancies were found in the areas of getting along with family, improving job skills, health and medical problems, drinking problems, drug problems, and improving interpersonal relations.

These findings are in keeping with the observations in a San Francisco study.⁵³ It found that the hierarchy of needs expressed by homeless users of psychiatric services in the downtown area did not correspond to the services that mental health professionals made available to them. Although the homeless persons interviewed had two or more voluntary contacts with acute or emergency psychiatric services in the two months preceding the interviews, the frequency with which they rated mental health resources as a need was much lower than those for housing, entitlements, or employment.

A study of service utilization and preference patterns of homeless persons at three sites in Boston — a shelter and treatment program for homeless persons who are also mentally ill and two publicly funded shelters — came to similar conclusions.⁵⁴ Help with housing, food or food stamps, job seeking, obtaining clothing, and benefits applications were needs homeless persons cited most frequently. The majority of the homeless persons interviewed had not sought mental health services in the six months preceding the interview, nor did they cite a need for such services. The authors state that “this is interesting in light of the fact that the interviewers, all of whom were experienced mental health workers, rated the majority of respondents from all groups as being in need of mental health services.”⁵⁵

Other studies illustrate the priority homeless persons give to material needs and the differences between goals set by social workers and those acceptable to homeless persons with psychiatric disorders.⁵⁶ One of the first evaluations of innovative service programs for homeless mentally ill individuals found that client disagreement over housing goals had a significant negative effect on the likelihood that the client would remain in housing once it was obtained. The authors write that “housing ‘placements’ sometimes came undone if programs did not ensure that the process of setting and pursuing service goals incorporated clients’ own perspectives on their needs and options.”⁵⁷

What accounts for such wide discrepancies between the need constructed by homeless persons and need constructed by researchers and service providers? Mulhern and Bradley point out that those homeless persons who attempted to obtain mental health services were by and large able to, “suggesting that accessibility to mental health care may not be a barrier for homeless persons, but acceptability may be.”⁵⁸ Public psychiatric services, of course, are not readily accessible in New York City and other areas of the United States for all who desire them, judging by the long waits in emergency rooms. However, regardless of supply, many former and occasional patients who have not consistently been part of the mental health “system” and who are not necessarily homeless express a similar reluctance to accept treatment.⁵⁹ Others desire treatment, but not the medication and constraints offered.⁶⁰ Fifteen years after mental illness was “discovered” among homeless persons, this response continues to be one of the most persistent themes in services for mentally ill homeless.

Relative disinterest in mental health services may reflect the greater need for material resources or prior negative treatment experiences. It may also reveal a lack of insight or awareness of a mental health problem. However, rather than interpreting homeless persons’ reluctance in seeking or accepting mental health services on the basis of a universal notion of need, we might do well to view such expression of autonomy as a critical consciousness of the situation. The low priority they give to psychiatric care may reflect conflicts between the value systems of two worlds⁶¹ or

dislike or inability to tolerate the rigidity of organizational structure and time,⁶² as well as the centrality of basic needs for shelter, food, and so forth. Refusing to "hear" such needs has adverse effects on service planning and may lead to extreme consequences, such as creating absolute and meaningless (as suggested above) categories of mentally ill homeless. Rather than interpreting the expression of non-mental health needs as resistance, the context in which they are voiced should be examined. This points to the way mental health services are organized, the multiplicity of agencies a homeless person must deal with, and the continual shrinking of resources. Furthermore, programs that meet homeless persons at the point where they are do exist; examples include "low-demand, no-questions-asked" approaches, as well as services that emphasize engagement and trust building as precedents to intervention or involve clients in management,⁶³ such as the Heights Residence in New York City, Women of Hope in Philadelphia, and a number of consumer-run alternatives, such as the Independence Support Center in Oakland.

On empirical grounds, then, we can question that the mental health needs identified in surveys affect policy directly. However, the very concept of need that underlies this policy research can also be challenged. Using psychiatric status as an indicator of need presents a further danger. It promotes a circularity by which the supply defines the demand. That is, by defining the needs of homeless persons in terms of psychiatric dimensions and symptoms, the service itself — hospitalization or treatment — becomes the social goal. This circularity in turn legitimates and reinforces the existing system (or nonsystem) of services⁶⁴ while preempting the possibility of other types of responses. It also removes from the universe of discourse (social policy) any indication of the macro-level changes that create and affect the day-to-day situation of homeless persons.

Alternative Classifications and Alternatives to Classification

The circularity created by constructing need through psychiatric status parallels the equation of homelessness and mental illness. In fact, it amounts to a "psychiatrization" of a social problem. Using single signifiers to cover the multiple problems of poor people is, of course, not new in American welfare history. In the two earlier major crises of the United States in this century, the thirties and the sixties, the pattern of intervention was similar: individualizing cases, categorizing and isolating the poor, multiplying the agencies distributing aid, with the effect of denying that poverty is a social and political problem. In this approach, social problems are increasingly turned into psychological ones, by redefining them as problems of individual pathology and deflecting attention from their fundamental social, economic, and political causes.⁶⁵ While psychiatry plays a role in this process, it takes place regardless of the formal involvement of psychiatrists, as some concurrence exists between the culture of psychiatric professionals and the hegemonic values of American culture.

Is there an alternative to classification by psychiatric status that might break the circularity described? The question begs consideration both because classification is inevitable at this stage in the emergence of homelessness as a social problem and because the fact that some homeless persons suffer from severe psychiatric

conditions requires responses as immediate as that of housing for homeless persons in general.

A first suggestion would involve shifting emphasis from a static characteristic to the resources one has for negotiating the experiences of everyday living, or survival. For some time now, psychiatrists and researchers have been questioning the usefulness of a psychiatric diagnosis for treatment purposes. Diagnosis neither provides knowledge of the context of distress or illness nor suggests which types of treatment are preferable.⁶⁶ Perhaps the one exception to this statement is a primary diagnosis of substance abuse or a dual diagnosis of substance abuse and psychiatric disorder. In fact, such diagnoses make getting into treatment harder, because the individuals fall between two treatment systems and bodies of knowledge. The substance-abuse label also makes it less likely to obtain other resources, such as housing.

Psychiatric research suggests that symptoms and diagnosis may not be the most useful predictor of who will be referred to what service or of who does best where. Instead, both stressful experiences in an individual's life and how well he or she had been able to negotiate everyday life (for example, work, social relations) may be more useful in suggesting the intervention that should be made available and the results that could be expected.

Among persons with schizophrenic disorders, for example, future behavior has been shown to be predicted best not by symptoms but by past behavior in the same outcome domain, such as employment.⁶⁷ A study that examined a wide range of psychiatric disorders found that the decision to hospitalize rather than refer to outpatient treatment is most highly correlated with current adaptive functioning.⁶⁸

These study results confirm what clinicians have long observed — in their language, that stress and level of functioning are important predictors of a need for treatment. In what is almost a research cliché, two leading researchers who are attempting to unravel the “nature” of the course of schizophrenia showed that the social competence a person diagnosed as schizophrenic demonstrates before onset of the illness is his or her best prognostic indicator.⁶⁹ People may be impaired in some areas (symptoms) but not others (ability to work). These researchers also conceptualize separate systems of functioning. We might reinterpret these as domains of everyday life which one is able to negotiate: treatment, social relations with others, obtaining and retaining resources, and so on. While these are clearly interrelated in an individual's concrete lived reality, past performance predicts future performance in the same domain: past hospitalization predicts future hospitalization, past employment predicts future employment, and so forth.

In an attempt to clarify the concept of chronicity in mental illness, Bachrach raised the question of whether it refers to active symptoms or to functional disabilities.⁷⁰ This clarification is important given the assumption that it is chronically mentally ill homeless persons who are most in need of services.⁷¹ Symptoms of illness may be present without disability, as we saw above. Similarly, difficulty in day-to-day functioning may persist long after primary symptoms of the illness have disappeared. Some aspects of that disability, as Estroff's ethnography of patients living in community-based settings suggests,⁷² are produced by social interaction with people and organizations, as well as by the experience of illness, and may persist without the illness.

Evidence from research concerning homeless persons with psychiatric problems adds further grist in suggesting that competence in everyday life, or so-called level of

functioning, is more predictive than symptoms or diagnosis — with the exception, again, of substance abuse. In an evaluation of programs for mentally ill homeless, two aspects of competence — personal care and community skills — predicted who got into housing within a six-month period. In the 1987 New York City municipal shelter survey, level of functioning also predicted the interviewers' rating of type of housing a homeless client needed.⁷³ These ratings were part of a needs assessment made by the interviewers after they had spent, on the average, an hour and twenty minutes asking questions about demographic background, residential history, mental health, health, substance abuse, and other client characteristics. Interviewers were asked to place clients' housing needs on a continuum, ranging from independent housing to partly supervised housing to inpatient treatment. An interviewer's evaluation of client's competence, a client's ability to function, contributed more to the rating than did such mental health indicators as client's self-reported depressed mood and psychotic ideation, interviewer's rating of psychotic behavior, or history of psychiatric hospitalization.

Although measures of adaptive functioning may be preferable to measures of psychiatric status for social policy research, level of functioning presents its own sets of problems. First, level of functioning does not escape thorny issues of validity. A major problem in using level-of-functioning rating scales concerns the contaminating effects of environmental contingencies, which were discussed in relation to psychiatric symptoms. Several studies of homeless persons have noted the confounding of poor functioning with adaptation to a hostile or resourceless environment.⁷⁴ Among the direct effects of environment are dangerous or noisome conditions that affect sleep and concentration; food retrieved from garbage, or donated or routinized meals that affect ability to eat nutritiously; overcrowded and violent shelter conditions; and danger of physical or sexual assault or theft in the streets, which affect interpersonal relations.

Finally, level of functioning resembles too closely another administrative category, disability, that plays a large role in the distributive politics mentioned earlier.⁷⁵ As Stone later demonstrated for categories of policy research, the level-of-functioning measures, when isolated, emphasize one characteristic at the exclusion of others that may be equally as important.⁷⁶ In this metaphorical process, level of functioning, or its inverse, disability, becomes a symbol, as does psychiatric status. As such, it is both ambiguous and elastic, shaped by political agendas and economic priorities. In the Social Security Administration's recertification policy in the early 1980s, thousands of individuals were thrown off the Supplementary Security Income rolls as the incapacity to work was narrowly defined by the presence of symptoms.

To these elements of classification should be added two other types of indicators. A truly social, rather than psychiatric, "diagnosis" should include some signs of the community or network to which an individual has been attached. Becoming homeless happens in a social context, and disaffiliation from major social institutions does not necessarily mean detachment from other human beings.⁷⁷ Second, needs articulated by homeless persons themselves must be incorporated into their classification. Many surveys, as was shown above, contain this information. However, in diffusing findings, each element is broken up and isolated from the other, thus reflecting only a fragment of the lived experience of the individuals described. In this process psychiatric status tends to take on disproportionate importance.

An alternate to classification can take place to the stage of developing a plan of action. Needs can be articulated at several levels. The examples presented thus far focused on the individual level. Collective expressions of needs can emerge in a dialogue among potential clients, on the one hand, and advocates, service providers, and planners, on the other. In the field of mental health, some examples exist of the organization of services and resources that evolve as needs are brought to awareness, are redefined, or change. Bachrach described this process in idiosyncratic programs for new types of mental health consumers.⁷⁸ Other examples are evident in the democratic psychiatry movement in Italy⁷⁹ and in recent experiences such as psychiatric consumer-run housing and drop-in centers. The action-research of European poverty programs and of earlier periods in the United States formalize some of these practices.

Finally, needs may be articulated through collective actions. This is the case with Union of the Homeless's taking over of empty public housing and with the homesteading movement in New York City and elsewhere. Psychiatrically vulnerable homeless persons, while not figuring prominently, have nevertheless been involved in collective ventures such as living in abandoned buildings or shantytowns.

Whether an alternative classification or an alternative to classification is developed, we can conclude that psychiatric classification is overinterpreted. As shown, classification efforts too often serve the desire of administrations to define homelessness as someone else's problem or to meet the needs of other interest groups. These same measures and categorical schemes will not allow us to answer disparate but crucial questions about whether homelessness is due to personal or societal failings, which governmental agencies contribute to it, what agencies are responsible for responding to it, and what specific approaches are needed to change the situation, regardless of its causes. ♪

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Notes

1. Herbert Blumer, "Social Problems as Collective Behavior," *Social Problems* 18 (1971): 298-306. Blumer's conceptual scheme is applied specifically to contemporary homelessness by Mark J. Stern in "The Emergence of the Homeless as a Public Problem," *Social Services Review* 58 (1984): 291-301.
2. Michael Harrington, *The New American Poverty* (New York: Penguin, 1984).
3. Stern, "Emergence of the Homeless."
4. This term was suggested as a conceptual framework for developing programs by HUD assistant secretary Anna Kondratas (U.S. Department of Commerce, Bureau of the Census, *Enumerating Homeless Persons: Methods and Data Needs*, Washington D.C., 1991), 13.
5. The administrative category "single adults" actually includes many people who are married and/or have children, according to representative surveys of the New York City municipal shelter system (Elmer L. Struening, "A Study of Residents of the New York City Shelter System" [New York: New York State Psychiatric Institute, 1986, revised 1987]).
6. Celia W. Dugger, "Panel Report on Homeless Is Criticized by Dinkins' Staff," *New York Times*, February 1, 1992, 1,26.

7. Robert R. Reich and Loren Siegel, "The Emergence of the Bowery as a Psychiatric Dumping Ground," *Psychiatric Quarterly* 50 (1978): 191-201.
8. Kim Hopper and Jill Hamburg, "The Making of America's Homeless: From Skid Row to New Poor, 1945-1984," in R. Bratt, C. Hartman, and A. Meyerson, eds., *Critical Perspectives on Housing* (Philadelphia: Temple University Press, 1986).
9. Examples abound, from articles in the widely diffused weeklies (*People*, *Newsweek*, and others) to films such as Terry Gilliam's *The Fisher King*.
10. Kim Hopper, "More Than Passing Strange: Homelessness and Mental Illness in New York City," *American Ethnologist* 15 (1988): 155-67.
11. Carl I. Cohen and Kenneth S. Thompson, "Homeless Mentally Ill or Mentally Ill Homeless?" *American Journal of Psychiatry*. In press.
12. The methodological problems with these earlier studies were critiqued in Bruce P. Dohrenwend and Barbara S. Dohrenwend, "Social and Cultural Differences in Psychopathology," *Annual Review of Psychology* 25 (1974): 417-52.
13. David A. Snow, Susan G. Baker, Leon Anderson, and Michael Martin, "The Myth of Pervasive Mental Illness Among the Homeless," *Social Problems* 33 (1986): 301-17.
14. James D. Wright, "The Mentally Ill Homeless: What Is Fact and What Is Myth?" *Social Problems* 35 (1988): 182-91.
15. See, for example, Sue E. Estroff, *Making It Crazy: An Ethnography of Psychiatric Clients in an American Community* (Berkeley: University of California Press, 1981), and Erving Goffman, "The Insanity of Place," his appendix to *Relations in Public* (New York: Harper & Row, 1971).
16. Irving O. Piliavin, Herb Westerfelt, and Elsa Elliott, "Estimating Mental Illness Among the Homeless: The Effects of Choice-Based Sampling," *Social Problems* 36 (1989): 525-31.
17. American Psychiatric Association, *Diagnostic and Statistical Manual of Mental Disorders*, (3rd ed.) (Washington, D.C.: American Psychiatric Press, 1980, revised 1987). Hereinafter cited as *DSM III-R*.
18. All the studies discussed in this section are reviewed in tables by and available from me (Anne M. Lovell, New York State Office of Mental Health, 75 Morton Street, 7B14, New York, NY 10014). Two types of psychiatric indicators — the homeless person's self-report of treatment history or need for mental health services and a service provider's brief assessment of psychiatric status — are less commonly used today and methodologically less sound than the other three indicators. They are discussed in Anne M. Lovell, Sue Barrow, and Elmer Struening, "Between Relevance and Rigor: Methodological Issues in Studying Mental Illness and Homelessness," in René Jahiel, ed., *Homelessness: A Prevention-Oriented Approach* (Baltimore: Johns Hopkins University Press). In press.
19. Paul Koegel and Audrey Burnam, "The Prevalence of Specific Psychiatric Disorders Among Homeless Individuals in the Inner City of Los Angeles," *Archives of General Psychiatry* 45 (1988): 1085-92.
20. William R. Breakey, Pamela J. Fisher, Morton Kramer, et al., "Health and Mental Health Problems of Homeless Men and Women in Baltimore," *Journal of the American Medical Association* 262 (1989): 1352-57.
21. Ellen L. Bassuk, Leonore Rubin, and Laurel Alison Lauriat, "Characteristics of Sheltered Homeless Families," *American Journal of Public Health* 76 (1986): 1098-1100. Another possible reason for differing rates is the definition of homelessness that is used. The definitions chosen are value laden and as much a political as a research decision. In applied research, who is called homeless depends on the prevailing "ceiling of decency" in housing, as Peter Rossi calls it, and varies from residents in emergency shelters, to the precariously housed or doubled up, to people staying in flophouses or welfare hotels.

22. Anne M. Lovell, Sue Barrow, and Elmer L. Streuning, "Measurement Issues in Services Research on the Homeless Mentally Ill," in J. Franks and M. S. Levine, eds., *Proceedings of the Eighth Annual MSIS National Users Group Conference* (Orangeburg, N.Y.: Nathan S. Kline Institute, 1984). See also the selections in U.S. Department of Commerce, *Enumerating Homeless Persons*.
23. Peter H. Rossi, Gene A. Fisher, and G. Willis, *The Condition of the Homeless in Chicago* (Amherst: Social and Demographic Research Institute, University of Massachusetts, and Chicago: NORC, A Social Science Research Center, University of Chicago, 1986).
24. Peter H. Rossi, "Lessons from the 1985-1986 Chicago Homeless Study," in U.S. Department of Commerce, *Enumerating Homeless Persons*.
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Indemnified in a January Soup Kitchen Line

Ray Hall, Jr.

This noon you noticed Portland's chimneys.
They belonged to another time this cold day:
no one in Portland was upset
because those chimneys were smokeless.
Like a dinosaur's bones in a museum,
and making a useful skyline,
they asserted the recurrence of interesting fossils.
It was easier then, in that beat line,
getting that mystifying lesson about remains
that it takes looking at emptiness first
to find the shape that you may happily depend on.
The good intruder into nothingness is anachronistic,
but, assuredly, clean, and bone.

Ray Hall, Jr., is a contributor to Pile of Papers; Stack of Karma, a collection of poetry published by the Portland Coalition Press. Reprinted with permission.

The Kindred Bonds of Mentally Ill Homeless Persons

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While the unraveling of the kinship bond has long been suspected to play a role in the epidemiology of homelessness, the connection between kinship and homelessness has been little studied. Based on a normative analysis of the role of family structure in response to adversity, this article explores the impact of the amount and quality of kinship ties on episodes of homelessness experienced by discharged psychiatric patients in Ohio. Survey data derived from personal interviews with both former patients and their kin indicate more strain in relations with kin of the homeless than the nonhomeless. The strain in the kinship bond appears to emanate from a greater prevalence of chronic disabilities that undermine independent functioning and tax the resources of relatives who choose to remain involved. Consistent with this interpretation, patients with histories of homelessness reported more psychiatric symptoms, more deficits in daily living skills, and more contact with the criminal justice system. In general, patient variables were better able than family variables to differentiate the homeless from the nonhomeless. Nonetheless, the formulation of public policies for reducing the incidence and prevalence of homelessness will surely need to take account of the kinship bond and how it can be strengthened.

All through its history, the United States has had homeless persons, the number and composition varying from period to period. Contemporary homelessness has special characteristics that reflect current social trends. First, homeless persons are currently more visible because there are more of them and present police practices do not confine the homeless to skid row. Although there

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were many homeless in the Great Depression, in the prosperous post World War II decades the number of homeless declined to the point that observers predicted the demise of skid rows by the middle 1970s. However, contrary to expectations, homelessness increased dramatically in the 1980s. Encountering the homeless on the streets and in public places became a commonplace event in everyday urban experiences. Second, the characteristics of homeless individuals of the current period are different from those of the past. The post-World War II homeless population was dominated by old men — average age in the fifties — living in single-room-occupancy and flophouse hotels and showing high rates of alcoholism.¹ In the nineties, the average age of homeless persons is in the middle thirties, half or more are from nonwhite ethnic groups, a quarter or more are women, and a third to a half command at least a high school education.²

Most observers agree that contemporary homelessness is largely the outcome of three major, mutually amplifying social trends: the diminishing supply of low-cost housing, especially in inner cities; changes in the economy lowering demand for employment of unskilled persons; and a sharp decline in the real value of entitlement benefits.³ The end result in the 1980s was a drastic increase in the number of Americans in extreme poverty, some of whom became homeless.

Not all the extremely poor become homeless; only a small minority do. The majority manage to obtain shelter and subsistence through the material help given to them by their kin and friends. Indeed, homelessness is a sign that our kinship ties sometimes fail either to exist or to function. First, several observers note that larger-than-expected proportions of the homeless received out-of-home placement in foster care or group homes.⁴ For these, there were no kinship ties to fall back on. Second, as adults, many others have posed greater burdens than their primary kin could sustain: kinship obligations are strong but not indestructible.⁵ It is especially significant that the homeless manifest high levels of disabilities that are likely burdensome to their kin.

This article is concerned particularly with the relationship of chronic mental illness and homelessness. Virtually all researchers find that serious mental illness affects a minority, albeit sizable, among the homeless.⁶ By the same token, there is also much indication that the homeless are overrepresented among the mentally ill. For example, one recent study of patients admitted to a New York State mental hospital reported a rate of prevalence of homelessness of 19 percent in the three months preceding admission.⁷

Serious chronic mental illness is a disability that is an obstacle to achieving independent living. Employment opportunities are reduced. Self-care may be impeded. The capacity for social relationships may be severely diminished. Although income maintenance and human services programs can compensate for these problems to some extent, for many adults with serious mental disorders, their families of origin continue to represent a crucial social resource whose importance extends well past the transition to young adulthood. Without mental hospitals to take continuing responsibility for patient management, it is inevitable that former patients as well as community mental health workers turn to primary kin — parents, spouses, and children — during times of crisis. Whether primary kin are identifiable and accessible, and how they respond to requests for assistance, is often pivotal to whether a vulnerable and dependent adult joins the ranks of the homeless.

Strain in relations to primary kin is problematic as such (nobody wants to see family bonds unravel) but especially for vulnerable groups such as the severely men-

tally ill to whom the family may be the first line of defense against adversity. Linda Stoneall observed that deinstitutionalized mentally ill persons and their families oscillate between periods of closeness typified by assistance and periods of separation in which estrangement is the norm.⁸ Separation may occur when a mentally ill person rejects the demands and conditions of support imposed by family members or when family members can no longer tolerate the mentally ill person's failure to comply with these demands. Thus, one logical end point may be abandonment of the patient by the family, or conversely, abandonment of the family by the patient.

While the kinship relations of the severely mentally ill may be strained, most patients are able to keep ties unbroken to at least some family members to whom they can turn during difficult times. What factors differentiate such kin ties from others that are broken or in the process of unraveling? To consider this problem, it is instructive to think about the normative contingencies that govern kindred relations in general.

Contemporary Kin Ties

Of all the social supports available to persons in any society, kinship ties are the most enduring. The mutual-support obligations existing between spouses are among the strongest, upheld both in law and custom. Accordingly, married couples share common residence, the same standard of living, and provide mutual support in many ways. The ties between parents and children, perhaps the strongest, are asymmetrical, at least as long as the child is a minor: In all fifty states, parents are obligated under law to provide support for children under the age of eighteen. Parents provide the basic necessities for their minor children and typically provide support well into early adulthood. Of course, an important difference between the marital and parental bonds is that the former can be terminated whereas the latter, in most cases, "is forever."⁹

Other kin relationships carry weaker obligations for support. Obligations to affinal kin — "in-laws" — derivative of the spousal bond, are weaker than for corresponding consanguinal kin and wither away after divorce. For Americans, the kindred sharing significant obligation levels excludes cousins of any degree or more remote kin. For all practical purposes, the kinship-support system includes spouses, parents, and children at its core, with minor ties to in-laws, siblings, grandparents and grandchildren, and uncles and aunts.

A kinship-support system works normally when members carry out the roles of their age and gender positions. Marriages become fragile when spouses cannot carry out their marital roles. Despite the recent changes in the common definitions of husband and wife roles, husbands who are unemployed and wives who cannot "keep house" often find themselves in the divorce courts.

Similarly, parents do not begrudge providing room and board to their minor children but may find an unemployed thirty-year-old living at home to be a burden. An adult might offer a sibling some temporary shelter during an episode of unemployment but balk at sharing a home indefinitely. In essence, adult kin are expected to be self-supporting financially and to form their own support kin networks through marriage and parenthood. Although this does not mean that adults cannot count at all on their kindred, it does mean that support is limited in duration and quantity. Primary kin may be those to whom an adult can turn for psychological support and temporary financial help, but long-term extensive care is problematic.

These characteristics of our kinship system have important implications for the care of adults with serious mental disorders. Typically, a person who is discharged from a mental hospital or other twenty-four-hour psychiatric setting is someone who has not been able to fulfill expectations concerning normal adult functioning. Many have never married. For those who did marry, the marriages typically were dissolved. Employment patterns before hospitalization were intermittent and precarious. After discharge, employment prospects may be even dimmer. Furthermore, these problems are not likely to go away in the near term. The major implication of these characteristics is that the obligations of primary kin toward severely mentally ill adults are limited. Surely every parent feels some responsibility toward his or her adult child, but that obligation is not all inclusive.

Further complicating matters may be the nature of the mental condition of the afflicted individual. Kinship obligations may be stated as a categorical imperative, but they are sustained to some degree by reciprocity. A withdrawn, self-centered person may need psychological support but may appear to the donor as an unresponsive recipient. If bizarre and erratic behavior is involved, continued contact may be unpleasant and possibly even risky. In short, seriously mentally ill persons often make unresponsive, unpredictable, and even unpleasant visitors, let alone housemates, a consequence that may further weaken an already tenuous kinship.

Generosity is also conditioned by capacity. The relatively affluent with their great discretionary income and large homes may have the greater capacity to extend aid to their kin, while those whose income is closer to subsistence and consequently living in closer quarters may not have as much capacity. As a consequence, the kinship-support systems of the poor are a fragile reed to count on for many adults with severe psychiatric problems. Under such conditions, we can anticipate that only the closest primary consanguinal kin will offer to incorporate a discharged mental patient into their households.

Maintaining social relationships of any depth can be expected to be problematic, and the more severe the mental disorder, the more fragile the relationship. This fragility is one of the main connections between chronic mental illness and the homeless. It is the generosity of those kin, largely parents, who act upon obligations going beyond the prescribed that makes it possible for many persons with serious mental disorders to live through episodes of adversity. When such episodes show promise of becoming long term and when the recipient is not a grateful recipient, the obligation can wither, throwing a mentally ill person on his or her own resources, a capacity too meager to sustain independent living.

Recent Research

Without firm knowledge of what are "normal" levels of contact with kin, it is difficult to interpret the findings of studies of the homeless or the mentally ill. The majority of homeless persons in recent studies report that they have been in contact with a family member or friend,¹⁰ but the extent or depth of these contacts is unclear. We do know that family involvement is largely restricted to consanguinal primary kin, since one to two thirds of all homeless persons have never married. Although contact is limited, kin appear to be more frequently utilized as sources of social support than friends. Homeless persons in Baltimore¹¹ and Detroit¹² were more likely to remain in contact with family members than to have friends with whom they were in

contact. Unfortunately, researchers typically do not offer detail on which kin are covered in the rubric "family," although we can venture that mainly primary kin are involved.

The study of family relationships is therefore important in and of itself, because kin are integral to the social networks of many homeless mentally ill persons. As such, the number and quality of these relationships, and the patterns of assistance that they provide, contribute — positively or negatively — to the quality of a former patient's life. For homeless mentally ill persons, relations to primary kin seem to be particularly strained. Researchers in Los Angeles¹³ found that homeless mentally ill individuals had more impoverished social supports (low contact with family/friends, poor relations with family, more negative early family experiences, and fewer feelings of attachment to kin) than the non-mentally ill homeless. Studies in Boston¹⁴ and Milwaukee¹⁵ found that mentally disabled homeless persons were less likely than non-mentally ill homeless persons to be in contact with relatives.

Peter Rossi's analysis of homelessness in Chicago led him to conclude that the unraveling of the kinship bond may take a number of years, hence is a gradual process ending with the exhaustion of the patience and tolerance of family and friends.¹⁶ He estimates that the average life of tolerance and help is about four years, that is, the average period of unemployment experienced before becoming homeless, a period during which family and friends provided housing, food, and other amenities.

The Approach

We examine the impact of the amount and quality of kinship ties on episodes of homelessness experienced by former patients. The data derive from interviews with both former patients and their kin. Although a number of previous studies of the mentally ill included "family involvement" as a variable, none actually conducted interviews with these family members. This is hardly surprising; interviewing family members of the homeless is difficult, because the subject matter is especially sensitive when kin ties have deteriorated. Furthermore, many former patients either do not have any living relatives or do not acknowledge their existence.

This article compares the kin ties of mentally ill persons who report recent episodes of homelessness with others who report no such history. Because family relationships are reciprocal and interactive, perceptions of the kinship bond are viewed from the perspectives of both the mentally ill person and their kin. From each of these perspectives, we examine whether the kin ties of the homeless are in fact more strained, and whether deterioration of the kinship bond can be explained in terms of general characteristics of mentally ill persons and their kin.

Methods

In mid-1988, as part of the National Evaluation of the Robert Wood Johnson Program on Chronic Mental Illness,¹⁷ a total of 283 patients from Cincinnati, Columbus, and Toledo, Ohio, were identified in Ohio state psychiatric hospitals or twenty-four-hour crisis care facilities using selection criteria that emphasized the acute nature of the patient's condition. Patients were interviewed shortly after discharge, at which time they were asked to name up to four members of their immediate family. If patients gave fewer than four names (most did), they were asked to name other rela-

tives or particularly close friends. Approximately 7 percent gave no names or addresses, stating that they had no family or friends. Another 10 percent declined to provide names and addresses, thereby refusing permission to interview any family or close friends. At the patient level, the analysis includes the former patients for whom at least one family/friend interview was completed as well as those who had no one to name. Those who refused to identify family or friends are excluded ($n = 31$).¹⁸ These criteria for inclusion and exclusion resulted in a total patient sample of 252. The patients were 51.6 percent male, 51 percent were under thirty-two years of age, 46.4 percent were black, 53.6 percent had twelve or more years of education, 15.9 percent were living with a spouse or partner, and 91.7 percent identified family or friends to be interviewed.

A total kin sample of 365 persons was interviewed (largely in person) between October 1989 and March 1990. The response rate for the kin study was 79 percent. The major categories of kinship were mother (30%), father (11%), sister (18%), and brother (12%). A variety of other kin relations were also represented (29%), including small numbers of daughters and sons, wives and husbands, aunts and uncles, grandmothers and grandfathers, nieces and nephews, cousins, in-laws, and the step and half relations of blended families.

The average age of the kin respondents was forty nine (48.58) years. More than two-thirds (68%) were female. As many as 39 percent had less than a high school education. Slightly more than half the kin respondents were black. The proportion of kin respondents currently living with a patient was 16.4 percent. Nearly a third (30.6%) reported 1988 household income as less than \$10,000.

While the profile of patients is similar to that of prior studies, the profile of kin differs from those of many prior studies of family members with mentally ill relatives in having a greater variety of kinship ties, less education, lower income, and a higher proportion of blacks.

Measuring Homelessness

To measure homelessness, the former patients were read a list of "places where people sometimes sleep when they have nowhere to stay," including "outside without shelter," "inside an empty building," "in a public shelter," and "in a church." Patients were asked whether they had slept in any of the four types of places in the year prior to hospitalization. A summary measure was constructed by combining answers to the four items, resulting in three categories: (1) never, or zero episodes of homelessness; (2) less than thirty nights in the previous year spent in a homeless condition; and (3) more than thirty nights homeless in the year prior to hospitalization.

Measuring Patient Characteristics

In addition to conventional demographic characteristics, the patient interviews obtained measures of the quality of relations with kin. "Satisfaction with family"¹⁹ was based on the following items: How do you feel about: (a) your family in general; (b) how often you have contact with your family; (c) the way you and your family act toward each other; (d) the way things are in general between you and your family? A seven-point scale with end points labeled "terrible" and "delighted" was used to record responses. The latter were averaged to create a summary index. The internal consistency (coefficient alpha) of the index was .903.

We also constructed a measure of each patient's "faith in their families," based on answers to "If you were in trouble, such as needing money, something to eat, or needing someone to talk to, who, if anybody, could you usually count on to help you out?" If a patient mentioned spontaneously a spouse/partner, parent, brother/sister, or another relative, the response was coded as 1 (0 otherwise).

Measures were also obtained to use as indicators of the seriousness of the patients' disabilities and of unemployment. An index of "deficits in living skills" was constructed by adding up affirmative responses to the following questions: In the month before you were admitted to the hospital did you need help: (a) with things like grooming, bathing, or dressing; (b) taking medicine; (c) with housework and laundry; (d) with things like shopping for groceries; (e) with cooking or preparing your meals; (f) with traveling to places you needed to go, like the doctor or to do errands; (g) managing your money; and (h) deciding how to spend your free time? The internal consistency (coefficient alpha) is .716.

The severity of the patients' conditions was further assessed using a measure of "psychiatric symptoms" constructed from thirty items from the Hopkins Symptom Checklist 90.²⁰ Patients were asked how much discomfort each problem had caused them during the past week. The problems represented in the thirty-item version of the SCL-90 cover psychotic thinking, paranoia, and depression. Some examples are "hearing voices that other people do not hear," "crying easily," "feeling that you are watched or talked about by others," and "feeling others do not understand you or are unsympathetic." Response categories were 1 = not at all; 2 = a little bit; 3 = moderately; 4 = quite a bit; and 5 = extremely. The reliability (alpha) of the summary index constructed by averaging all thirty responses is .936, indicating a high degree of internal consistency despite the variations in types of symptoms.

Contact with the criminal justice system was measured by self-reported "arrests," coded 1 (0 otherwise) if the patient reported being arrested or picked up by the police for any crimes during the past year, and "nights in jail" coded 1 (0 otherwise) if the patient reported spending at least one night in jail during the past year.

Patients' employability was measured by asking each patient whether he or she had "earned income" in 1988 or worked or been involved in a "work or training" program or any other work activities, whether paid or unpaid, during the past year. In both cases, responses were coded 1 if yes (0 otherwise).

Measuring Characteristics of Kin

To measure kin perception of their "involvement" with the patient, family members were asked, How deeply are you involved with [name of patient]? The response categories were 1 = not involved; 2 = slightly involved; 3 = somewhat involved; and 4 = very involved. To further define the content and extent of kin involvement in assisting former patients, kin were asked how often in the past thirty days they had helped by providing transportation, helping with shopping, preparing meals, helping with household chores, and offering advice. The index of "help provision" is an average of help given (alpha = .804).

Family members were also asked whether during the past thirty days they had personally paid for or given money to pay for each of a list of items ranging from typical everyday necessities, such as shelter and transportation, to personal needs, such as cigarettes and pocket money, and medical expenses. For each affirmative

response, the family member was asked to estimate the amount given. The sums involved were then added to create a summary measure of "money given" to the mentally ill relative.

To measure "positive attitudes" toward the patient, family members stated their agreement (1 = strongly disagree; 2 = disagree; 3 = ambivalent; 4 = agree; 5 = strongly agree) with the following items: (a) I enjoy being with [name of patient]; (b) I'm very proud of [name]; (c) [Name] makes me happy; (d) [Name] is pretty easy to get along with. Responses were averaged to construct a summary measure of attitudes toward the patient. The internal consistency (coefficient alpha) is .81.

A measure of "network support" was constructed from items, patterned after the General Social Survey, asking kin to identify up to five persons with whom they had discussed important matters over the last six months. For each relationship, we asked: During the past thirty days, did you and [discussion partner] discuss problems concerning [name of patient]? Affirmative responses were coded 1 (0 otherwise) and averaged across network relationships. The result can be interpreted as the percentage of personal network members with whom the respondent discussed the patient. The higher the percentage, the more it may be inferred that the respondent was sufficiently involved with the patient to share such concerns with others.

"Worry about the patient" summarizes responses to five items ($\alpha = .818$), reporting how much they worried (1 = not at all; 2 = a little; or 3 = a lot) about (a) the patient's safety, (b) not getting needed services, (c) having little or no social life, (d) poor physical health, and (e) current living arrangements.

To measure resources available to the family which may set limits on their generosity, kin respondents were asked to report total 1988 "household income" from all sources before taxes. "Household size," an indicator of physical resources, was a count of the total number of people, including the respondent, who were living in the respondent's household at the time of the interview. Social resources was indicated by "network size," which was a count of the number of discussion partners reported in the network inventory.

Results

Table 1 shows the prevalence of homelessness as reported by patients in interviews that took place shortly after discharge. The first column summarizes patients' combined homelessness experience. As shown, 78.2 percent said they had never been in a situation in which they had nowhere to stay. Just over 14 percent said they had in fact been in this situation, but not for more than a cumulative total of one month. The remaining 7.5 percent stated that they had been in this situation for at least one cumulative month or more in the preceding year. Thus, a total of 21.8 percent reported between one and 365 nights of homelessness in the year prior to admission. The median number of nights homeless was ten.

Table 1 also shows the places where homeless persons slept for at least one night. A total of 12.3 percent reported having slept outside without shelter, 5.2 percent said they had slept in an empty building, 15.1 percent said they had slept in a public shelter, and 1.6 percent said they had slept in a church. These are not mutually exclusive sleeping arrangements. For example, nearly one half (47.4 percent) of those patients who reported sleeping outside also reported use of a public shelter.

Table 1

**Place Slept by Frequency in Year Prior to Hospitalization
(n = 252)**

Frequency in Past Year	Combined Homelessness Experience (%)	Slept Outside Without Shelter (%)	Slept in an Empty Building (%)	Slept in a Public Shelter (%)	Slept in a Church (%)
Never	78.2	87.7	94.8	84.9	98.4
Less than one Month	14.3	10.3	5.2	9.9	1.6
At least one Month	7.5	2.0	0.00	5.2	0.00
Total	252	252	252	252	252

Table 2 treats homelessness as a binary state, with patients who reported any experience of homelessness in the past year (21.8 percent) contrasted with those who reported none. The typical profile of those characterized as homeless is predominantly that of a young male not living with a spouse (or a partner, if married). Of those who were able to identify family or friends who could be interviewed, 20.4 percent reported at least one homeless condition, while 38.1 percent of those who were unable to identify any kin or close friends reported a homeless condition. This, in itself, supports the idea of a link between familial ties and homelessness.

As in other studies of the homeless, the average age was in the early to mid-thirties, and almost one half were drawn from nonwhite ethnic groups (see Table 2). Of the

Table 2

**Background Characteristics of Homeless Mentally Ill
Persons in Year Preceding Hospitalization (n = 252)**

	Homeless in Past Year (%)	N of Cases	Significance of Difference
A. Gender			
Male	30.0	130	p < .001
Female	13.1	122	
B. Age			
Under 32	24.2	128	NS
32 & over	18.7	123	
C. Race			
Black	20.5	117	NS
White	23.0	135	
D. Education			
12 or more years	18.5	135	NS
Less than 12 years	25.6	117	
E. Lives with spouse/partner			
Yes	7.5	40	p < .02
No	24.2	211	
F. Has family or friends			
Yes	20.4	231	p < .06
No	38.1	21	

patients who were high school graduates, slightly fewer than one-fifth were homeless. Of those who were not high school graduates, the proportion of homeless was just over one-quarter. While the relationship between educational attainment and homelessness was not statistically significant, it is in the direction observed in previous studies of the homeless. Similarly, although not significant, we find that younger patients are overrepresented among the homeless. Blacks were over-represented among the homeless relative to their proportion in the Ohio population, but were not more likely than whites to be found in the homeless condition. In fact, there was a slight underrepresentation of blacks reporting homelessness relative to their numbers in the total sample.

Chronic Disabilities and Poor Prospects

Family members are less likely to want to stay involved with persons with chronic disabilities, especially if the disabilities lead to disruptions in the household and the community. The potential for withdrawal is greater to the degree that the disorder is severe, the social consequences are salient, and the existing relationship is fragile. Table 3 contrasts the homeless and nonhomeless mentally ill with respect to the prevalence of deficits in daily living, psychiatric symptoms, and trouble with the law.

Table 3

Clinical and Social Characteristics of Mentally Ill Persons (n = 252)

	Total (n = 252)	Homeless	Nonhomeless	Significance of Difference
Psychiatric symptoms (mean)	2.35	2.59	2.28	p < .03
Deficits in daily living (mean)	1.77	2.44	1.60	p < .01
Arrested in past year (%)	28.6	32.7	27.4	NS
In jail in past year (%)	22.2	34.6	18.8	p < .02
Earned income in past year (%)	35.9	43.6	33.7	NS
Work or training in past year (%)	46.4	60.0	42.6	p < .03

Examination of Table 3 reveals considerable support for the chronic disabilities hypothesis. Persons with recent histories of homelessness report more deficits in daily living as well as more psychiatric symptoms. They are also more likely to have been in jail during the past year. Homeless persons were also somewhat, although not significantly, more likely to have been arrested. While the observed pattern of greater disability and trouble with the law among the homeless is not surprising, it is still noteworthy, because most prior studies of the homeless mentally ill have not included a nonhomeless comparison on these factors.

Table 3 also compares the homeless and nonhomeless in terms of the potential for economic self-sufficiency that may be associated with psychiatric disability. Surprisingly, there is no evidence that the prospects of the homeless for becoming self-supporting are poorer than in the comparison group of nonhomeless persons. In fact, the homeless persons under study were *more likely* than those without episodes of homelessness to report that they worked or were involved in a work or training program during the past year. There was also a nonsignificant tendency for the homeless to be more likely to earn income during the past year.²¹

Family Roles and Resources

Analyses of the distribution of family characteristics, shown in Table 4, revealed that similar proportions of primary kin (e.g. parents, siblings) were interviewed in both groups. This is somewhat surprising because of the tendency already reported for homeless persons in the sample to be more likely to state that they had no family or friends who could be interviewed. Evidently, the latter were a small group and the remainder were as able and willing as the nonhomeless to identify kin to be interviewed. The fact that the interviewers probed for multiple nominations (up to 4) may also account for the large numbers of primary kin in both groups. An alternative possibility is that the homeless in the present study had been in that condition for a short time only, and that relations with kin had not yet deteriorated to the point which observers commonly associate with persons for whom homelessness has become a chronic condition. Whatever the reason, the comparability of kinship between groups produces a methodological benefit since it is possible to link homelessness to family resources without the confounding effect of family role.

Table 4

Characteristics of the Kin Respondents (n = 365)

Characteristic	Total (n = 365)	Kin of Homeless (n = 77)	Kin of Nonhomeless (n = 288)	Significance of Difference
Parent (%)	40.8	41.6	40.6	NS
Child (%)	7.7	5.2	8.3	NS
Spouse (%)	3.6	0.00	4.5	NS
Sibling (%)	29.9	31.2	29.5	NS
Other kin (%)	18.1	22.1	17.0	NS
Low income (% <\$10,000)	28.5	31.2	27.8	NS
Household size (mean)	3.2	2.9	3.3	p < .08
Network size (mean)	3.3	3.1	3.4	NS

Table 4 switches the unit of analysis from the patient to the kin interviewed and focuses on the resources that the patients' families possess. The critical contrast is between the 77 kin of patients who reported homelessness and the 288 kin of patients who reported no such episodes. We expected that the kin of the homeless would be poorer, live in more crowded circumstances, and have more limited social support networks. Meager monetary, physical, and social resources may make it more difficult for kin to extend hospitality to dependent adults, and in this way help to explain why these particular kin were not the safety net of last resort between the patient and homelessness.

However, examination of Table 4 reveals little support for the meager resources hypothesis. The proportion reporting family income of less than \$10,000 (an indication of poverty) was 31.2 percent among the kin of the homeless as compared to 27.8 percent among the kin of the nonhomeless. Neither this difference nor that associated with network size is statistically significant, contrary to expectation. Household size, an indicator of limited physical resources, was actually higher in the kin of the nonhomeless ($p < .08$).

Perceptions of the Kinship Bond

Table 5 presents perceptions of the kinship bond from both patient and kin perspectives. The patients' views are shown in Panel A, and those of the kin in Panel B. It is

Table 5

Perceptions of the Kinship Bond

	Total (n = 252)	Homeless (n = 55)	Nonhomeless (n = 197)	Significance of Difference
A. Patient-Reported				
Satisfaction with kin (mean)	4.45	3.88	4.61	p < .01
Faith in family (%)	61.1	40.0	67.0	p < .001
B. Kin-Reported				
Involvement (mean)	3.18	2.86	3.26	p < .01
Gives Care (mean)	.77	.55	.83	p < .02
Gives Money (mean)	44.15	42.64	44.55	NS
Positive Attitudes (mean)	3.59	3.39	3.64	p < .05
Network support (%)	57.9	48.2	60.5	p < .02
Worry (mean)	2.10	2.07	2.11	NS

important to note that the sample sizes ($n = 252$ patients; $n = 365$ kin) associated with the relevant comparisons vary depending on the unit of analysis employed.

Panel A contrasts the homeless and nonhomeless patients in terms of how satisfied they are with their family and whether they feel they can count on their relatives during a crisis. Examination of these data strongly suggests that patients with histories of homelessness have more strained relations with their families. They are less satisfied with their family relationships and report less faith that they can turn to kin during hard times.

Mirroring differences reported by the patients, family members of the homeless also reported more relationship strain (see Panel B). Specifically, they reported less involvement with the patient, less caregiving, fewer positive attitudes toward him or her, and they were also less likely to discuss the patient with members of their social network. Although the families of the homeless appear in these ways to be more withdrawn from the patient, there is no significant difference between their level of worry and the worry of the families of the nonhomeless. Nor is there a significant difference in the amount of money given as assistance to patients.

Summary Model for Predicting Homelessness

The preceding analyses of homelessness were conducted at the bivariate level. While they accurately describe relationships between individual variables and homelessness, they ignore whatever may be the relationships among the independent variables and can be usefully supplemented by a multivariate approach that allows for effects to be estimated *ceteris paribus*. Table 6 uses a logistic regression procedure that is appropriate to a binary dependent variable.

Table 6 shows the logit results where homelessness is analyzed as the probability of occurrence within the past year (1 = yes, 0 = no). This probability was predicted using the variables from the preceding bivariate analyses that were significant at the .05 level. Variables derive from both kin and patient reports. Since there may be more family members than one per patient, such patient variables as gender and symptomatology are repeated within families.

The results reveal that the probability of homelessness is linked to being male, having deficits in daily living skills, and having spent time in jail during the past year.

Table 6

**Logit Coefficients for Predictors of Homelessness
(n = 335)**

Independent Variable	Logit Coefficient	Significance
Patient is female	-.746	p = .037
Patient lives with spouse/partner	-.707	p = .191
Patient psychiatric symptoms	.327	p = .157
Patient deficits in daily living	.351	p = .000
Patient in jail in past year	.709	p = .048
Patient worked or in training in past year	1.046	p = .002
Patient satisfaction with kin	.042	p = .725
Patient faith in family	-.688	p = .081
Kin involvement	-.072	p = .726
Kin gives care	-.352	p = .148
Kin attitude toward patient	.007	p = .971
Kin network support	-.002	p = .685
Constant	-2.507	p = .024

The unexpected result that working or receiving vocational training is associated with an increased probability of homelessness is also obtained in the logit model. In addition, there is a tendency among those patients who report little faith in their kin to have a higher probability of being homeless.

While the logistic results showed that a number of patient variables were statistically significant, it is noteworthy that none of the family measures were significant even though each had been at the bivariate level. This indicates that family characteristics do not differentiate the homeless from the nonhomeless when patient characteristics are statistically controlled. The effects of those family attitudes that were significant at the bivariate level appear to have been mediated by patient variables.

Discussion

Homelessness needs to be viewed in the context of extreme poverty in America and of the failure of societal institutions to provide minimally decent levels of care and support to its most vulnerable members. The failure of the society to provide support to families with dependent adults is a significant part of this larger problem. While much research indicates that families can and do make considerable sacrifices to support dependent adults for short periods, we predicted that their generosity is apt to reach its limits when their own resources are exhausted, when the behavior of the patient is extremely disruptive, or when psychiatrically disabled kin show no ability or willingness to seek employment or present much prospect of becoming employed in the near term.

We did not find support for all these hypotheses in the present study. The resources of the kin of the homeless were no more meager in financial, physical, and social terms than those of the kin of the nonhomeless. More support for the meager resources hypothesis may arise from more heterogeneous samples. The current sample, derived largely from kin of state hospital patients who were much too poor to seek services from the private sector, was drawn predominantly from the urban lower and working classes. We did find support for the chronic disabilities hypothesis on a number of dimensions. Compared to the nonhomeless, the homeless reported

more psychiatric symptoms after discharge, more deficits in daily living before going into the hospital, and they were more likely to have spent time in jail during the year prior to their hospital or crisis center admission. While the economic prospects of the persons reporting homelessness for becoming self-sufficient were no less than those of the nonhomeless, this may merely reflect the desperation that motivates homeless persons to find short-term work and earn money when they have no alternative social support to fall back on, or the assertiveness of case managers in getting these persons to accept vocational training.

There was far less ambiguity in the results surrounding the perceptions of the kinship bond. These data clearly document strain in the kinship bond from the perspectives of both the former patient and his or her family. Patients who acknowledge episodes of homelessness report less satisfaction with kin as well as less faith in them. For their part, kin of the homeless report less involvement with former patients, provide less informal care, acknowledge more negative attitudes, and are less likely to share feelings about their psychiatrically disabled relative with members of their personal network. The fact that they worry no less and give no less money is testimony to the fact that in most cases full disengagement has not (yet) occurred.

Future research is needed to test more clearly the assumption that the unraveling of the kinship bond is causally prior to homelessness. The problem is that cross-sectional surveys cannot disentangle cause from effect, nor distinguish homelessness that is episodic and tied to situational factors and temporary reversals from homelessness that continues for much longer periods. In view of the methodological difficulties involved, it might be prudent to begin with a sample of persons who are precariously housed and living with primary kin and to conduct follow-up interviews with the parties involved at some future date, for example, two years later. If sufficient numbers of dependent adults become homeless during the study period, comparisons could be made before and after episodes of homelessness. Longitudinal research patterned along these lines would allow examination of how the kinship bond may unravel in the face of unemployment, psychiatric disability, and homelessness. Ideally, it would also be possible in such a study to identify the place where interventions could most usefully be focused.

There is also a need for research to consider whether and to what extent formal support (services under professional auspices) is substitutable for informal support (family and friends). Although most homeless persons possess social networks of nontrivial size — Lovell reports an average network size of eleven persons²² — there is considerable dispersion around the mean in network size, and some homeless persons do in fact epitomize the stereotype of the individual who is alone and bereft of family and friends. The extent to which it is possible to shore up an impoverished social network, to renew family ties, or to substitute for such through relationships with professionals and paraprofessionals certainly deserves systematic inquiry.

In terms of public policy, our findings indicating significant strain in the kinship bond are most consistent with interventions emphasizing assertive case management and other related community support services.²³ The provision of supportive services to discharged patients may help preserve or improve their relationships with parents, siblings, and other relatives by reducing their dependence on kin. Relationships will of course be aided to the extent that treatment is successful in diminishing the signs and symptoms of chronic disability. With proper support and encouragement, some of these kin may also be willing to join with professionals in helping a former

patient look for work, find acceptable housing, and apply for welfare benefits, particularly if assistance given is viewed as steps to facilitate independence.

Another short-term consideration is relevant to hospital discharge policy. Patients with severe mental disorders should not be released to the streets. The process of community care should begin *before* release from a hospital or crisis care unit, and it is important that family support be mobilized to the extent possible around the transition represented by discharge. When kin are able and willing to be involved, professionals should support family members before the fragile bonds fray and the process of withdrawal begins. Interventions involving outreach to families, including financial stipends in exchange for providing shelter to a psychiatrically disabled relative, may also be useful as a means of shoring up kindred relationships and preventing homelessness.

Families cannot be expected to substitute for mental health professionals in twenty-four-hour shifts. While some families may be willing to act as the "safety net of last resort," at least for a time, they may require a variety of professional supports. Given that long-term structural issues are unlikely to be resolved in the current economic climate, it is necessary to utilize the existing social and mental health services. The failure of the present system to deal adequately with the disabling consequences of mental illness is in part responsible for the unraveling of kinship bonds, which, in turn, increases the relative risk of homelessness. ❧

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Housing, Community Support, and Homelessness

Emerging Policy in Mental Health Systems

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This article summarizes the dramatic changes in public policy through which public mental health systems are attempting to meet the housing and community support needs of persons with severe and persistent mental illnesses, including those who are homeless. It traces the historical approach to meeting these needs through defining people principally as patients and providing some combination of psychotropic medications, outpatient therapy, and structured, supervised quasi-institutional settings such as group homes, shelters, and segregated single-room-occupancy, or board-and-care facilities. A transition phase in public policy has emphasized defining these individuals essentially as service recipients who need greater or lesser amounts of community support services to avoid institutionalization. This policy focus, while less institutionally oriented than past policies, did little to alter the kinds of housing approaches planned for them. An emerging set of values and policies, which represents a paradigm shift in the field, now focuses on these persons first as people and as citizens, with rights, responsibilities, and needs like those of all citizens. Implications of this new set of policies for mental health systems are discussed.

This article summarizes emerging trends in providing individuals with serious and persistent mental illnesses, including those who are homeless, with decent, safe, and affordable housing, along with the supports they need to participate fully in the lives of America's communities. Meeting these needs is a significant public policy challenge, one which has been the subject of considerable debate, as well as what appears to be a somewhat surprising policy consensus in recent years. On the one hand, the literature describes the "failure of deinstitutionalization" and the need for "asylum,"¹ the national crisis of homelessness,² the low quality of community and hospital programs in mental health,³ and the orientation toward "maintenance" rather than rehabilitation⁴ in most public mental health service systems. Although mental health policies stress the need for community support systems,⁵ most resources are still used for institutional programs,⁶ and the broad implementation of "model" community support programs appears to be a rare phenomenon.⁷ The literature also includes debates about the lack of attention to consumers' rights.⁸

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On the other hand, we also find significant attention paid in the literature to the development of more effective community support services,⁹ acknowledgement of the importance of consumer empowerment,¹⁰ more responsive and respectful clinical interventions,¹¹ and a clearer emphasis on meeting basic needs for homes, jobs, and friends, which all citizens share.¹²

Considering these dramatically conflicting views, it has been suggested that the field is in the midst of a "paradigm shift." Ridgway and Zippel summarize the major dimensions of this shift as a home (not residential treatment settings); choice (not placement); normal roles (not a patient or client role); client control (not staff control); social integration (not grouping by disability); in vivo learning in permanent settings (not transitional preparatory settings); individualized flexible services and supports (not standardized levels of service); and a focus on the most facilitative environments, and on long term supports (rather than on the least restrictive environment, and "independence").¹³

The implications of this paradigm shift for public policy have been described by Carling¹⁴ as representing a fundamental change in assumptions about the people that systems serve, from an era of institutional and facility-based thinking that characterized people essentially as "patients," to a "transitional" period in which people were seen principally as "service recipients" needing a primarily professional support system,¹⁵ to a world view in which people are seen as "citizens" with a potential for, and a right to, full community participation and integration.¹⁶ In this respect, it is interesting to note the parallel evolution of public mental health policy in Canada, in which the case is the major policy thrust — rather than being focused on "community support systems," as in the United States — emphasizing a "framework of supports,"¹⁷ in which it is assumed that people should be primarily sustained through self-help and peer support, then draw on "folk" or "natural" support systems, such as friends, family, neighbors, and coworkers, then on such generic community services as common social outlets, generic health care, and so forth, and *only then* on the professional mental health system. That system's purpose is *not* to be the primary treater or intervenor, but the force which bolsters the other support networks, so that reliance on professional interventions is either minimally necessary or significantly reduced over time.

It is clear that the field of public mental health is in the midst of a major rethinking of the nature, characteristics, and needs of the people it serves and the roles and responsibilities that derive from dramatically different ways of thinking about its "customers." To answer critical questions about whether such a process of rethinking is likely to effect major changes in public policy nationally, to facilitate the restructuring of federal, state, and local programs designed to meet the needs of these individuals, and, most important, lead to observable changes in the life opportunities for these persons, however, it is important to understand the evolution of these changing policies.

During the early years of press attention, the public perception of homelessness, as well as federal, state, and local policies, focused on people with a mental illness who are homeless, seemed to assume that these persons represented a distinct subgroup whose characteristics and needs were fundamentally different from those of other people with serious and persistent mental illnesses or of citizens in general who carried no label.¹⁸ Such policies and programmatic responses were fueled by the public perception linking homelessness and mental illness into one amorphous group of "strange" or "marginal" people. In this context, it is clear why the predominant response of federal, state, and local government, as well as of mental health professionals, has once again been a focus

on treatment in specialized settings. Alternative approaches are possible, of course, but until recently, few systems seemed prepared to tackle what, for mental health policy-makers, has seemed an overwhelming issue: the lack of affordable housing and limited availability of high quality, flexible, and attractive community support services.

In fact, there is considerable evidence that the apparent link between homelessness and mental illness is much more complicated. A high proportion of people with mental illness have never been hospitalized;¹⁹ it is extremely difficult to ascertain the effects of homelessness, as contrasted with those of mental illness, on the human psyche; many people with serious mental illness appear to be “episodically homeless,” moving in and out of a condition of homelessness, often linked to the availability of income or the use of mental health residential programs or hospitals; and the use of widely differing definitions of homelessness, including some that categorize all individuals in psychiatric hospitals or residential programs as “at risk of homelessness” has become increasingly problematic.²⁰

Do people with mental illness who are homeless systematically differ from those with mental illness who have a home? There are few studies where people with mental illness live. A broad range of studies²¹ on where people with this label *want* to live, however, reveals a high level of transience and residential instability.

This article assumes that there are no fundamental differences between people with mental illnesses in general and those who, at a given time, happen to be homeless. There are, to be certain, particular service approaches that appear to be more relevant to people who are homeless while they are being served, but at least at present, there does not appear to be any substantial evidence that the fundamental needs of these individuals differ in any significant ways from those of others who are served in public mental health systems.

Background and Scope of the Problem

Since the late 1950s, this country has significantly reduced public hospital use and expanded community services.²² A focus on stable housing linked to supports, however, has emerged only in the last ten years.²³ Although research has been relatively scant in this area, major public policy studies have concluded that a majority of the 1.7 to 2.4 million Americans considered “long term mentally ill” based on diagnosis, disability, and duration of disorder²⁴ live in inadequate housing, lack needed supports, or are homeless.²⁵ The problem is complex: without active rehabilitation, many persons lack the skills and supports necessary for successful community living. The recurring nature of psychiatric disabilities may also result in the loss of housing with repeated hospitalizations.²⁶ Housing discrimination is rampant, as landlords refuse to rent to these individuals.²⁷ Most people with psychiatric disabilities are poor, with average annual incomes from \$3,000 to \$7,000, and unemployment rates as high as 85 percent.²⁸ A recent national study of the extent to which individuals on a Supplemental Security Income (SSI), the most typical income source for individuals served by public mental health systems,²⁹ concluded that *there is not a single county* in the United States where these individuals can afford either an efficiency or one-bedroom apartment, using the federal Department of Housing and Urban Development’s (HUD) standard of affordability. This lack of income, coupled with the stigma and public rejection associated with mental illness, appears to represent the major barrier that people who are homeless and mentally ill face in their quest for decent housing.

Failure of public mental health systems to focus on decent and stable housing means that as many as one third of inpatients remain in psychiatric hospitals unnecessarily.³⁰ Others cycle through emergency rooms and general hospitals in costly and often inappropriate stays.³¹ Others are “placed” in “custodial” nursing and boarding homes, which lack rehabilitation or treatment, contribute to declines in functioning, and are often exploitative.³² The lack of stable housing and support substantially burdens families,³³ who serve as case managers and landlords with little or no support. Those who do find housing often live in very low-income neighborhoods with substandard dwellings and high crime rates. “Oversaturation” of these neighborhoods by people with disabilities often leads to community backlash.³⁴ An increasing number are homeless: studies reported that as few as 10 percent and as many as 75 percent of people who are homeless have severe psychiatric disabilities³⁵ although they have not necessarily used mental hospitals.³⁶ Finally, these individuals compete for housing with other low-income groups, most of whom are generally viewed as more suitable tenants.

As public outrage about homelessness has grown, along with the public perception linking most or all homeless people with deinstitutionalization, and given traditional role definitions for mental health and traditional assumptions about the incapacities of “mental patients,” many mental health systems have, at least initially, remained passive as a whole new industry of service providers began developing alternative “facilities” for this new “special population” of people with mental illness, such as shelters and segregated single-room-occupancy hotels.³⁷

The Affordable Housing Crisis

The housing problems faced by people served by public mental health systems are compounded by dramatic changes in the current housing scene, where a decade-long decline in affordable housing stock, and the rising cost of housing in relation to income, reduce access to decent housing for *all* people with limited incomes. Home ownership is out of reach of the middle class, as is decent housing, for most people at or below the poverty level. These trends have included a cut of nearly 80 percent in federally assisted housing for low-income and special-needs groups since 1981, and a dramatic increase in homelessness in all parts of the country.³⁸

Because disabilities can be economically catastrophic, people with disabilities are disproportionately represented among the “very poor” — those with 20 percent of median income — and even lack access to “affordable housing” programs, which typically require 50 percent to 80 percent of median income. Paradoxically, since access to affordable housing has become a national crisis, the public’s support for increased federal and state spending and taxation for this purpose is at an all-time high.³⁹ Thus, even as federal housing programs were being cut in 1988, Congress was drafting sweeping new affordable housing legislation to reverse these trends,⁴⁰ as well as new disability-related legislation. Passage of the National Affordable Housing Act, the Fair Housing Amendments Act, and the Americans with Disabilities Act all represent a major set of opportunities to introduce innovative strategies for more successful community integration to the public agenda through a focus on housing.

Mental Health's Response

Historically, the mental health field has considered housing a social welfare problem and defined its role as "treatment." The public housing field, reflecting societal stigma, contends that mental health consumers need "specialized residential programs," for which mental health is responsible.⁴¹ Housing needs are ignored: residential services typically produce treatment facilities, not housing. Transitional halfway houses "proliferated in the 1960s. In the 1970s, the concept of a "residential continuum" emerged, including "quarterway" and "halfway houses";⁴² "three-quarterway houses";⁴³ "family foster care";⁴⁴ "crisis alternative models";⁴⁵ "Fairweather Lodges";⁴⁶ "apartment programs";⁴⁷ "boarding homes";⁴⁸ "nursing homes";⁴⁹ and "homeless shelters".⁵⁰ These programs have typically been segregated, professionally staffed, and congregate in nature.⁵¹

The Current State of Practice

A national survey of over twenty-five hundred community residential programs in all states serving adults with psychiatric disabilities⁵² found that a relatively small number of agencies actually provide these services in most states. In spite of the continuum model, few agencies offer more than one option. Most programs were large congregate facilities, accounting for fewer than a quarter of the settings but most of the residents. Newer supervised apartment programs use larger numbers of standard-size households, an approach more consistent with "normalization" principles.⁵³ Intermediate care facilities, nursing homes, and shelters had few formal ties with mental health services. Transitional housing, with time limits, was not as common as expected. Most programs provided long-term services. Residential services, although assumed to be "intensive," are staffed primarily by paraprofessionals who have not been trained in the traditional mental health care disciplines. Follow-up services were essentially informal, suggesting that efforts to assist clients to find and maintain stable housing may be relatively weak. Sixty thousand individuals received services from these residential programs. Extrapolating that figure to the survey universe, the authors concluded that, nationally, fewer than 5 percent of people with psychiatric disabilities live in such settings.⁵⁴ This is consistent with state estimates that between 2 percent and 5 percent of people with psychiatric disabilities are served in residential programs.⁵⁵ Individuals served were primarily young adults with diagnoses of major mental disorders. Using a functional rating scale, over half the programs served persons with moderate to severe disabilities. The rest served people who were either gravely disabled or functional; surprisingly, these programs served *twice* as many persons who were functional as they did those who were gravely disabled. This finding contradicts the popular notion that residential programs serve those with the most severe disabilities and raises serious concerns as to whether such scarce resources should be serving so many persons who are functioning relatively well.

Evaluation of Residential Program Approaches

Our knowledge about "what works" in residential programs is hampered by both methodological and conceptual problems. Few evaluations of community residential

services have been rigorous enough for conclusions to be drawn.⁵⁶ Also, since the goals of community programs are rarely well defined, most outcome evaluations have been conceptually flawed. The most frequent evaluation question is whether community programs are more successful than institutional treatment in helping persons achieve more independent living. In six major reviews covering several hundred "alternatives to hospitalization," only a handful of studies met basic criteria of experimental design.⁵⁷ Taken as a whole, these studies indicate that community-based treatment is virtually always as effective as or more effective than hospital-based treatment in helping people with psychiatric disabilities achieve employment outcomes, gain reentry into the community, and reduce the use of medication and outpatient services. Apparently, any of a wide range of community services can assist in achieving some measure of community integration.

With regard to residential programs, Cometa, Morrison, and Ziskoven,⁵⁸ reviewing a total of 109 studies, concluded that evidence of the effectiveness of transitional halfway houses in reducing recidivism and improving economic self-sufficiency and community adjustment was "highly suspect." So transitional residential programs may in fact be preferable to institutional care, but according to this review, they fall considerably short of helping people achieve lasting housing or community integration.

Perhaps the most intriguing findings in this area came from an extensive study of sheltered care environments conducted by Segal and Aviram⁵⁹ and a review by Tabor,⁶⁰ which indicated that characteristics of the *community* are more important than characteristics of *residents* in predicting the degree to which people actually participate in community life, while specific characteristics of the facility were the least important factor. These studies suggest that outcome research should be reframed to focus on where people live and how they spend their time, rather than only on the interventions that professionals provide. There have been few rigorous evaluations of specific residential programs, and even fewer attempts to examine professionals' success in helping people get and keep normal housing. Lack of information on program effectiveness is a critical deficit, which can result in grossly inefficient use of resources and, most important, seriously curtailed opportunities for people with psychiatric disabilities, particularly those who are homeless.

Problems with Traditional Approaches

It is clear from the literature on residential services and on the emergence of new models, that residential programs do not, per se, meet housing needs. In fact, serious questions have been raised about confusing residential treatment and housing, or assuming that people who are institutionalized or homeless need such programs prior to "independent living."⁶¹ The growing acceptance of a rehabilitation approach⁶² demystifies acquiring stable housing by defining it as a process of building critical skills and supports to "choose," "get," and "keep" the housing one desires. A range of research and training activities undertaken by the Center for Community Change (CCC) at the University of Vermont, partly in collaboration with Boston University's Center for Psychiatric Rehabilitation, has revealed significant dissatisfaction among consumers, their families, and service providers with the concept of a "residential continuum" and with the "transitional services" model. In a summary, Carling and Ridgway⁶³ criticize the notion that "transitional" stays in residential settings is a simplistic approach to "independent living," which creates major difficulties for the indi-

vidual including: (1) having to learn skills that are mostly relevant to group living; (2) chronic dislocation through successive moves, since improvement in functioning requires a physical move; and (3) an ultimate return to family, boarding home, hospital, or homelessness, due to the inattention of many treatment-oriented systems to stable housing.

Similarly, the "residential continuum" allocates resources to separate facilities rather than to services and supports linked to normal housing. The transition and the continuum concepts often require participation in a service program in order to receive housing. These trends are particularly evident in the national explosion of shelters for people who are homeless, and of segregated "housing programs for the homeless." Such programs have, in part, been encouraged by federal policies and resource allocation strategies, such as are found in HUD's Section 202 and early McKinney Act programs, which required that housing be both segregated and congregate in nature. The findings are also echoed in the literature on developmental disabilities.⁶⁴ Based on these findings, Randolph et al.⁶⁵ recommended that the field move away from the concepts of a residential continuum, transitional and congregate programming, and focus instead on housing and supports; and that the field establish consumers' preferences and choices as the single most important determinant of the housing and support options available. So how can this approach be implemented?

Mental Health and Cross-Disability Literature

Two reviews of the research on psychiatric disabilities⁶⁶ summarize effective ways to provide people, including those who are homeless, with decent housing and ongoing support and conclude that: (1) this disability is not a lifelong degenerative process; (2) most people can maintain homes, jobs, and friendships; (3) services must be highly flexible to respond to individual needs; people with the most severe disabilities need the most individualized approaches; (4) people *can* make positive choices about needed supports; (5) people don't define themselves principally as "chronic mental patients," but value independence and productivity more than any other treatment outcomes.

Mental health also has much to learn from other groups who need special supports in their housing: people with low incomes, those who are elderly, and those with developmental disabilities, including mental retardation. A review of the research on housing and community integration for *all* disability groups⁶⁷ concluded that: (1) housing needs are similar for all groups, although support needs vary; (2) supports are the critical determinant of whether people can remain in their chosen housing; (3) housing problems relate less closely to disability than to economic and social factors such as poverty, affordable housing, and discrimination; (4) strong differences of opinion often exist between professionals and consumers about specific needs for housing and supports, regardless of disability group; (5) choices and control over one's environment are critical necessities; consumers want to be centrally involved in planning and managing their own housing and services; (6) elders and people with disabilities, without in-home supports, are plagued by transience, dislocation, and the risk of institutionalization; and (7) the model of a residential continuum is increasingly beset by conceptual and practical problems. This review concluded that the broader disability community is increasingly emphasizing normal housing and the need to avoid transforming housing into service settings. Thus,

community integration approaches avoid congregation and segregation, and instead focus on building relationships between disabled and nondisabled individuals.

Consumer Preferences

Finally, the preferences of consumers, including those who are currently homeless, are emerging as a powerful determinant of the need for housing and supports. In a countywide needs assessment in Washington State, Daniels and Carling⁶⁸ reported on data from providers and their clients about their perceptions of the need for housing and supports. Professionals and consumers held virtually opposite views about housing and support needs, with professionals favoring transitional, highly staffed residential programs for the great majority of consumers, and consumers expressing preference for normal housing with flexible supports. Most consumers preferred to live with one other person, rather than alone or in a larger group. The first statewide study of consumers' preferences for housing and supports was conducted in Vermont,⁶⁹ involving a random sample of individuals who were homeless, in the state hospital, or receiving community services. Most persons preferred to live in their own apartment or house (and, in fact, given financial support, to own their own housing), rather than in a mental health-operated facility, single-room-occupancy hotels (SROs), with their family, or in a community care (boarding) home. The major barrier consumers saw to realizing this preference was a lack of adequate income. Most people wanted to move to a better location, have more space in better repair, and have more freedom and autonomy. People in SROs were the least satisfied of all respondents, including those in the state hospital and those who were homeless. The most preferred characteristics of living situations were freedom and autonomy, permanence, security, and privacy. These preferences did not differ significantly across the three groups of respondents.

Traditionally, the field has assumed that many people need live-in staff to assist them during crises to teach them skills. Only one tenth of the respondents, however, wanted live-in staff. Most preferred that staff be available by telephone, or in person if necessary, on a twenty-four-hour basis. As contrasted with traditional "placement" into group settings, most people preferred *not* to live with other consumers, feeling that it was difficult enough to cope with their own problems. Instead, they wanted to live with a friend or romantic partner. In this and over forty-three similar studies reviewed by Tanzman,⁷⁰ it is clear that consumers, whether homeless, in a state hospital, or in community programs, can articulate their needs for housing and supports and overwhelmingly prefer integrated housing.

Consumer perspectives were also solicited in a national housing policy forum⁷¹ attended by a group of nationally recognized consumer leaders, all of whom had been homeless. Individuals recounted their own experiences with homelessness and residential programs, and concluded with the following recommendations. The group felt that systems should develop the housing options that most people prefer, independent or shared apartments with support services; that integrated, decent, and permanent housing should be developed in safe neighborhoods, near shopping, services, and transportation. They urged that support services focus on helping people develop skills, manage stress, deal with landlords, manage money, and seek support.

With regard to income, the group urged that disability benefit levels be improved and that special funds be made available to help people move into and keep hous-

ing, including loan funds for security deposits, rent subsidies, and creating employment opportunities. Participants called for improved case management with lower caseloads and higher pay and urged the creation of new staff roles, such as a personal care attendant model. They urged that staff be specifically trained to help people choose, acquire, and keep housing, and to value and respond to the consumers' perspective on needs. They urged that consumers be hired and trained as service providers, as outreach workers, case managers, skills teachers, and program managers.

Participants called for the development of self-help options, including user-run housing. They pressed for greater input into decision making, by conducting housing forums, using ex-patients to collect information, and always involving consumers in planning and developing housing and supports. They encouraged public education efforts to reduce stigma, including teaching public officials about consumers' concerns. The group urged tighter regulation of board-and-care homes, and stressed the need for further legislation for affordable housing. Finally, they emphasized the importance of working in coalitions, and keeping the public's awareness of this issue at a high level. Throughout this forum, participants stressed that the major barrier that mental health systems face in working with homeless people with mental illness is one of credibility: that mental health services are seen as unattractive and, in fact, dangerous, in that any involvement with "the system" puts one at risk for involuntary treatment.

The Emergence of a Supported Housing Approach

In summary then, the information gleaned from the community support and rehabilitation literature in mental health, from other fields, and from people with mental illness themselves, including those who are homeless, suggests that the key ingredients of community integration are a focus on consumer goals and preferences, an individualized and flexible rehabilitation process, and a strong emphasis on normal housing, work, and social networks.⁷² In the field of mental health, this approach has been termed "supported housing."⁷³ The National Association of State Mental Health Program Directors approved a policy statement that sharpens their focus and endorses the concept of "supported housing." It reads:

All people with long-term mental illness should be given the option to live in decent, stable, affordable and safe housing, in settings that maximize their integration into community activities and their ability to function independently. Housing options should not require time limits for moving to another housing option. People should not be required to change living situations or lose housing options when their service needs change, and should not lose their place of residence if they are hospitalized. People should be given the opportunity to actively participate in the selection of their housing arrangements from among those living environments available to the general public . . . Necessary supports, including case management, on-site crisis intervention, and rehabilitation services should be available at appropriate levels and for as long as needed by persons with psychiatric disabilities, regardless of their choices of living arrangements. Services should be flexible, individualized and provided with attention to personal dignity. Advocacy, community education and resource development should be continuous."⁷⁴

"Supported housing" is organized around three central principles: (1) consumers choosing their own living situations; (2) consumers living in normal, stable housing, not in mental health programs; and (3) consumers having the services and supports

required to maximize their opportunities for success over time. Reviews of characteristics of local supported housing programs,⁷⁵ and of related state-level innovations,⁷⁶ provide information on the specifics of this approach.

Implications for Public Policy

Systems that are moving toward a supported housing approach face significant challenges. Traditional funding streams, program requirements, administrative approaches to resource allocation and management, and even staff skills are not oriented toward intensive support for consumers in normal housing and work settings, particularly to individuals who reject traditional services, often for very legitimate reasons. Systems interested in being more responsive, rather than developing more residential programs, often emphasize developing better community services, increasing consumers' income through employment and subsidies, building relationships with the public and private housing sectors to access and develop housing, focusing on tangible outcomes from their service providers, and restructuring their policies, funding, and regulations to be consistent with these outcomes. Further, they attempt to fully involve consumer representatives in key aspects of their decision making.⁷⁷ Systems that have moved even further have curtailed future group home development or have begun "decongregating" these programs.⁷⁸ Key to success is a clear mission that articulates the role of consumers in this process, the types of housing options, and the types of services that will actually be available.

The Need for Further Research

As public policy appears to shift away from an expectation that transitional or other residential facilities will meet any significant proportion of the need for stable housing and community supports for people with mental illness who are currently homeless, more research into questions of where and how consumers prefer to live, successful strategies for facilitating meaningful client choices, for developing housing and supports, for developing relationships with people without disabilities, documentation of the costs and benefits of housing and support initiatives, identification of clinical interventions best suited to normal housing, and an elaboration of the role of peer support in community success, will all be vital. Research on supported housing has largely consisted of descriptive studies of current programs.⁷⁹ This is appropriate given the early state of evolution of the supported housing approach. In order to demonstrate the effectiveness of this approach, further studies that assist the field in putting into operation this set of concepts, as well as studies that assess its impact on consumers and their families, are essential.⁸⁰ Carling, Randolph, Blanch, and Ridgway⁸¹ concluded that further research is *not* needed on hospital versus community alternatives per se or on the efficacy of residential treatment settings (for example, group homes), particularly since these settings are so rarely operationally defined. The key unresearched questions, according to that review, are: Where do people with mental illness live? Who is especially at risk of homelessness? Where do people want to live? and How can we help them succeed there? In the final analysis, this policy shift will also require a shift from professionally defined to consumer defined research, focusing more on the commonalities between people with and without disabilities and defining "success" in terms of the aspects of quality of life that are important to all citizens. ♪

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Untitled

Kathie Boulanger

I hurt so good
The pain you feel is
not intentional
I'm naive about so much
Sometimes I don't know
how/what I'm doing
That's not me copping out —
but I just get stuck in
the machinery with
no way out
no way home
no home — no friends — no hope
I hurt so good
I'm still a little girl
and don't always understand
where you are
You've grown so much
I'm afraid it's away
from me

Kathie Boulanger is a member of the Portland (Maine) Coalition for the Psychiatrically Disabled. Her poem first appeared in Pile of Papers; Stack of Karma, a collection of poetry published by the Portland Coalition Press. Reprinted with permission.

Empowerment and the Transition to Housing for Homeless Mentally Ill People

An Anthropological Perspective

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Often lacking in scholarly and policy-oriented discussions of homelessness are contextualized understandings of the problems faced, and the values held, by homeless mentally ill people. This article, using an anthropological perspective, examines issues that arise for homeless mentally ill individuals in making the transition from shelter living to permanent residences. The transition occurs as part of a housing initiative driven by the philosophy of consumer empowerment. Project participants are placed in independent apartments or evolving consumer households (ECH) — shared, staffed residences designed to transform themselves into consumer-directed living situations over time. The effects of an empowerment paradigm on the organization of space, the nature of social relations, and the management of economic resources in the ECHs are discussed to show that consumers and staff sometimes have contrasting views of what empowerment entails. It is suggested that anthropological research can help to illuminate the issues at stake in determining policy for homeless people with major mental illness.

The problem of homelessness, particularly of individuals who are both homeless and mentally ill, continues to grow. Throughout the country, localities are struggling to find effective, and cost-effective, means of coping with the mental health and housing needs of this vulnerable population. Although a substantial body

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of services research data is beginning to accumulate (see, for example, Morrissey and Dennis 1990; National Institute of Mental Health 1991), these data tend to focus on such outcome variables as psychiatric symptomatology and days the individual spends housed (community tenure in a residence). Although useful for planners, these reports do not offer "thick descriptions" (Geertz 1973) of the rich observations and experiences gained in carrying out such innovative programs.

We bring an anthropological perspective to bear on the examination of a "consumer empowerment" approach to providing housing for homeless mentally ill persons. Focusing on the transition from shelter living to permanent group residence for a small number of individuals with major mental illness, we investigate the philosophy of empowerment as it is put into everyday practice in self-directed households involving "consumers" and residential staff. We analyze the effects of an empowerment paradigm on the organization of space, the nature of social relations, and the management of economic resources in the houses to show how anthropological research can lead to a better understanding of the issues at stake in determining policy for homeless persons with major mental illness.¹

An Anthropological Approach to Research on Homelessness and Mental Illness

Anthropologists take a distinct, not always fully understood, perspective on studying mental illness and mental health. Clinicians define psychopathology and the functioning of individuals as the problem to be addressed, examining how social forces interact with psychiatric illness to influence life course. Sociologists and policy analysts, meanwhile, focus on social and political institutions to ask how these institutions affect persons who suffer from mental disorder. By contrast, anthropologists have traditionally placed *culture* — that socially organized system of meanings, values, language, and social practices that mediate individual thinking and behavior — at the center of their analysis. We investigate personal experience and strivings, as well as the dynamics of group relations and interpersonal life, not simply in relation to larger social forces, but also in terms of the context, meanings, and values of the "local worlds" in which mentally ill persons live their daily lives.

A number of distinct epistemological principles underlie and inform anthropological inquiry and provide theory and method for the ethnographic enterprise. Above all, anthropologists seek to view the world through the eyes of the people they are studying in order to understand how they make sense of their experience. To the extent that what people do is determined by how they interpret what happens to them, grasping the meanings individuals attach to events becomes a way of understanding human behavior. For anthropologists, adopting the "insider's view" of the world is the primary means to this end.

An emphasis on attention to *context* also distinguishes anthropology from mainstream clinical and sociological perspectives. Attending to context means collecting data in and on natural settings while broadening the scope of analysis to include the sociocultural, economic, and political factors that structure and shape individual action. Studies carried out in natural settings reveal that people behave differently in different situations. At the same time, recognition of the complexity of context follows from the delineation of the multiple and interacting layers that it comprises.

Goffman's (1961) classic study of life in mental hospitals and other "total institutions" is a particularly compelling argument for the influence of context on behavior. By documenting similarities in social interaction across seemingly disparate situations, Goffman shows that these similarities stem from commonalities in the formal constraints imposed by the institutional environment, that is, from contextual factors.

Finally, anthropology affirms the importance of studying a situation over time. Insisting that there is no shortcut to understanding (and no better methodology than patience), anthropologists remain in the field for a year or more in order to participate in local activities, develop relationships, and witness the changes that take place in the lives of their subjects. An appreciation of change, like attention to context, is considered essential to the holistic perspective that characterizes anthropological research. The best studies of American street life, for instance, have come from sociologists and anthropologists who lived for extensive periods of time in urban communities and participated in their everyday life (see, for example, Whyte 1949; Rose 1987; Anderson 1990).

These three epistemological principles come together in ethnography, the time-tested anthropological tool for studying people and their behavior. Ethnography is both method and product in anthropological research. As method, it combines participant-observation, being with people to understand and share in their experience, with open-ended interviews in naturalistic field settings. As product, it offers an interpretive, usually book-length, analysis of a situation, a group of people, and a way of life.

Indeed, the holistic and insider knowledge that ethnographic research can produce seems especially important for the study of those who are homeless and severely mentally ill. These people are, in a sense, without voices. Life on the street is not easily understandable for any of us, however benevolent our intentions; as one woman told us, "You live on the other side of the world, you can't know what it's like to be homeless." Similarly, the very nature of major mental illness makes access to the lives of those affected particularly difficult. Not only do mentally ill persons seem less inclined to describe their experiences in the rich verbal and narrative forms valued by mainstream America, they are also slow to form the relationships of trust that necessarily precede frank talk about one's views of the world (Baxter and Hopper 1981; Corin 1990; Koegel, i.p.). The double disadvantage of homelessness and mental illness defines a population particularly vulnerable to being spoken for by others. This alone makes the representation of the insider's view a high priority for research on homelessness and mental illness.

Although the anthropology of homelessness is still in its infancy, several studies exist to illustrate the contribution an anthropological perspective can make to understanding homeless persons with major mental illness. Anne Lovell (i.p.), for example, has shown that different understandings of, and approaches to, the organization of time influence homeless people's adaptive use of urban facilities, a use which reinforces their marginal status. Baxter and Hopper (1981), Hopper (1988), and Koegel (1990), in turn, have shown that the meaning of temporary housing (shelters, single-room-occupancy hotels) for individuals who are chronically mentally ill — as a prison rather than a haven, as temporary and therefore unreliable, as relatively and unnecessarily expensive — helps to explain the rejection of proffered shelter, where it exists, in favor of life on the streets. Hopper (1988) has offered an alternative to "individual deficit" explanations of homelessness among mentally ill

persons, explanations that locate the cause of the problem in the impaired capacities of individuals themselves. He convincingly argues that economic and other structural aspects of social context (increasing poverty, gentrification, the shrinking supply of available housing) must be taken into account to understand adequately the origins of the problem. Finally, Koegel (i.p.) has shown that the constant and fundamental change that permeates the lives of those who are homeless and mentally ill (including their frequently transient lifestyles) can be grasped only by following people over time, a practice which, as we have seen, is a key element in anthropological research.

The Project

This work has emerged out of ethnographic research being conducted as part of a larger, comparative study of the effects of two housing models on clinical status, physical health, length of domicile, and other outcomes for those who are homeless and mentally ill. Permanent housing for 120 people is being provided as part of this research demonstration initiative, which also includes intensive clinical case management for those who choose to take part.

Participants are recruited from three shelters serving homeless people with mental illness in Boston, Massachusetts. Established by the state Department of Mental Health, these shelters accept only individuals with chronic and severe psychiatric illnesses. Residents are often referred to these facilities by outreach teams who work with homeless people in the streets and in other public shelters. Despite the fact that these special psychiatric shelters were originally intended only as *temporary* quarters, many participants had been living there for years when they were offered housing as part of the project. Before that, all had spent considerable time on the streets.

One of the shelters, managed by a private vendor, has been set up on a city-owned island in Boston Harbor in an abandoned structure formerly used as a hospital ward. The leaky, windowless basement of an old building on hospital grounds in a Boston neighborhood is the physical location for the second. The third consists of beds and partitions arranged on a basketball court in a downtown government building.

Having agreed to be included in the project, participants are randomly assigned either to independent living situations or evolving consumer households. Independent living situations (ILs) are studio apartments located in five public housing facilities in the city of Boston. Evolving consumer households (ECHs) are shared, staffed residences intended to transform themselves over time from arrangements resembling traditional group homes to cooperative living situations managed by the consumers themselves.² The mechanism mediating this process is consumer, or tenant, empowerment.

Empowerment

We begin to examine the meaning of empowerment by situating the term within the context of research and policy discussions focusing on housing for persons with mental illness. As deinstitutionalization began in the 1960s and services for the mentally ill moved into the community, housing was initially patterned on residences maintained on state hospital grounds. Over the past thirty years, models of halfway and quarterway group homes, subsidized apartments, board-and-care beds, and shelters were developed. These programs, however, have been challenged by

clinicians, researchers, and consumers of mental health services. They have been criticized as being overly regulated and infantilizing, transitional and time limited, and directed too heavily by professionals (Carling et al. 1987; Goering et al. 1990; Goldfinger and Chafetz 1984; Imbimbo and Pfeffer 1987; Ridgway and Zippel 1990).

Recent observers have formulated a number of objections to the routinization and depersonalization of community residence care, calling instead for services that emphasize diversity and flexibility (Boyer 1987; Goering et al. 1990; Cohen and Somers 1990; Witheridge 1990). Diverse and flexible services are those which seek to meet the basic needs of their clients while providing mental health care (Brown and Wheeler 1990; Segal and Baumohl 1988; Shern 1990). These types of services appear to be most meaningful to, and utilized by, difficult populations such as homeless people with major mental illness (Shern 1990; Goldfinger 1990).

These authors assert that the most effective housing programs are those which fulfill the needs and objectives asserted by clients themselves. These range from "home-like environments" in shelters through "consumer-run living centers" to "normal, independent living situations" (Goering et al. 1990; Harp 1990; Keck 1990; Ridgway et al. 1988). The consumer empowerment model is but one of many programs being implemented as part of the recent trend toward supported housing and client-directed residence care (Susser, Goldfinger, and White 1990).

To understand the meaning of empowerment for the Boston project, we may disassemble the general notion into its various constituent parts. At least four distinct but related principles are embedded in the empowerment philosophy as it applies to evolving consumer households.

First, empowerment means self-determination, which in turn means the exercise of control. From the beginning, tenants set house rules on such fundamental issues as whether alcohol will be allowed and what kinds of behavior will be considered unacceptable. Certain personal choices, such as whether to continue to attend a day program, are also left to the discretion of the individuals involved. Over the course of the project, tenants are expected gradually to assume control over decisions, on everything from household policy to when to take a shower; resources, such as money and time; and services received, including the number and activities of on-site staff and the development of goals for treatment. Self-determination, then, means that whenever possible, one defines one's own needs. Although it is recognized that, for some tenants, the need for help and staff presence may be lifelong, the primary goal is to maximize areas of self-determination and minimize unnecessary passivity and regulation.

Self-help is also part of the notion of empowerment. Self-help means learning to secure and administer proper amounts of medication, advocate for one's interests within the household setting and outside in the community, practice proper nutrition and personal hygiene, and manage one's own time — that is, doing for oneself the tasks that formerly required help from residential staff.

Since knowledge is required for the practice of self-determination and self-help, receiving and learning to ask for information is another aspect of the empowerment philosophy. This orientation presumes that tenants should *know* what their diagnosis is; what kinds of medication they are taking, in what amounts, for what purposes, and with what effects; what their income is; how much it costs to supply electricity and gas for a household of six; what is written about them in the daily

house logs, and so on. Such knowledge is considered essential if they are eventually to manage their house, and their lives, successfully.

Finally, empowerment embraces the principle of normalization. Normalization means leaving behind institutionalized housing for mental patients to take up residence alongside non-mentally-ill persons in the community. It means living like everyone else, in the sense of having a residence that does not include the presence of supervisory staff (or at least minimizes staff control and programmatic intrusion into daily activities). Shedding the identity of mental patient or shelter patient and replacing it with a sense of oneself as part of a larger community is also part of the normalization process.

The aim of empowerment, then, is independent living based on the ability, and the freedom, to exercise control and take care of oneself. The path to independence, however, weaves through interdependence. By sharing household expenses, tenants are expected to be able to meet the financial requirements of maintaining a home in the community.³ At the same time, the ability to break old habits of reliance on residential staff is seen as stemming from the development of mutually supportive relationships among household members. The unit of independence in this model, then, is not the individual, but the "autonomous group" (ECH Program Description, 1).

Nor is the severing of ties from the mental health system implied in the notion of independent living. The fact that ECH tenants suffer from major mental illness is not altered, for purposes of this project, by a commitment to empowerment. To deny this by expecting them to become independent of the need for treatment would be morally as well as clinically irresponsible. The concept of *living* like everyone else, therefore, does not extend to include *being* like everyone else. The presence of serious illness of any kind places limits of personal freedom that healthy persons do not have to confront. "You don't get choices about everything when you have a chronic illness," one senior investigator on the project put it. "If you're diabetic, you get insulin."

The Transition from Shelter to ECH

From a consideration of how empowerment is defined and interpreted in the context of this particular project, we turn to the question of how it is put into practice. Three different aspects of the transition from shelter to ECH living illustrate the implementation of the empowerment philosophy and the changes it brings to the everyday lives of those making the move. Nine months of fieldwork in both the shelters and the ECH households provide the basis for the discussion, which is intended to identify core issues in empowerment for both tenants and staff.

Privacy and the Politics of Space

What does a home mean to the homeless? "Home is a place that you can lock up," one man told us while sitting in a shelter one day. His neighbors tended to agree. Besides being able to lock up one's belongings, a home, for many, also implies owning the belongings themselves. When we asked another man what a home meant to him, he replied, "A stove, a fridge, your own TV." Someone else observed, in turn, that "home is a place to wash one's clothes, cook, and eat." Along with the stress on the *possibility* of doing what one needed to do in order to live (wash, cook,

eat), respondents also emphasized that *freedom* of action was part of the meaning of home. "Home is where you can sleep all day," one woman said in response to our query. These and other comments suggest that having a home for homeless people means, most of all, owning a private space where one can live in comfort and freedom.⁴

For almost all shelter residents, the extensive rules and regulations, in combination with the lack of privacy and comfort, mean that a "real home" cannot be found there. Indeed, the absence of private space is one of the most salient, and burdensome, features of shelter life. In a shelter, all spaces are penetrable by staff. They can enter at will the separate dorm areas of the male and female residents simply by shouting, "Female staff entering the men's dorm!" Several rooms in the shelters are locked, and only staff hold the keys. On entering a shelter, one immediately comes upon the staff desk. Only staff can move into the space it commands, a fact that residents are well aware of.

In contrast to staff, shelter residents are restricted in their movements. There are several places they cannot go, and certain times when they cannot remain in the shelter. Staff influence, to a great degree, what spaces residents may inhabit. For instance, staff can order a guest to take a "time out" if his or her behavior is deemed inappropriate;⁵ time out requires leaving the shelter for a specified period of time — an hour, an evening, a night.

These constraints on movement lead to particular ways of negotiating space in the basketball court shelter, where fifty-one beds are arranged in close proximity to one another. Here, sheer numbers often lead to a complaint of no privacy. Each night, every resident must sleep with approximately twenty other same-sex fellows on the same half court; no partitions separate the beds from one another. During the day, all the guests, male and female, share six tables, four armchairs, one couch, and one TV room. Most confrontations within the shelter involve disputes over these limited resources. One shouting match began, for instance, when a man bumped into another, spilling the coffee he was carrying; another took place when a woman intentionally chose a chair in the TV room that she knew another woman preferred to sit in. A typical tense moment occurred when a man sat down at a table where a woman was already seated. "I want to be alone," she said. "Alone?" he responded. "How can you be alone here? Everybody's together. You could be off somewhere by yourself." A minute later, the man left the table.

In fact, being "off somewhere" by oneself is one of the ways in which residents compensate for the lack of privacy in this shelter. Numerous benches, stairwells, and infrequently used hallways dot the shelter building and its surrounding grounds. Residents tend to frequent these "free spaces" (Goffman 1961) in order to be by themselves, sleep, or engage in sexual activity. While these nooks and crannies have traditionally offered at least some protection from constant exposure, recent changes in administrative policy have led to their being appropriated by other offices moving into the building. The former occupants, cautioned not to loiter, have thus found that the free spaces they thought they owned were in fact merely leased to them. Forced to fall back on other forms of privacy, residents erect invisible barriers around themselves, conveying to others through body language the advisability of remaining at a distance. Outside the shelter, they seek anonymity by going to a library, sitting on a park bench, or walking the streets.

The move to an ECH represents the acquisition of privacy for those who make the transition. New tenants move from the island, the basketball court, or the basement to a renovated single-family home or duplex. Well-trimmed grass and shrubbery surround the buildings, most of which are located in quiet, residential neighborhoods.

Upon entering an ECH house, one finds freshly painted walls, new carpeting, floors that have recently been refinished, and working fireplaces. Kitchens boast microwaves, dishwashers, and automatic coffee makers. There are a new television and stereo and comfortable sofas and chairs. Each of the five or six bedrooms is equipped with a new bedframe, mattress, and linens, as well as a chest of drawers.

Most tenants have their own bedroom; the rest of the space is shared with other tenants and staff. Staff as well as tenants watch TV in the living room, eat meals in the dining room, and store their food in the refrigerator. Staff office space is, to varying degrees in varying locations, situated within the common living area of the house, where it is both visible and accessible to tenants.

No longer forced to share sleeping quarters with twenty others, ECH tenants have either a room of their own, or a double — accommodations shared by no more than two persons. The large size of the living areas in the houses, together with the relatively small number of occupants, makes possible easy movement without bumping into, or sometimes even encountering, another resident. Furnishings are plentiful enough to allow everyone comfortable seating at the same time.

The fundamental importance tenants attach to having private space emerges in a number of ways. When asked what they like best about their new living situation, privacy is most often the response. The opportunity of having locks on bedroom doors was greeted with unreserved enthusiasm. Even the large amounts of time individuals spend in their rooms makes sense in light of the privacy these newfound “four walls” accord. Unlike a shelter, ECH living offers the luxury of being off somewhere by oneself without having to leave the premises.

Maximizing tenants’ sense of privacy is an integral part of the empowerment philosophy as implemented by ECH staff. We see this in their self-conscious effort to remain unobtrusive by retreating to office space whenever possible, “leaving the house to the tenants.” It is evident in the discomfort they express in opening the fridge to store or retrieve a lunch, thereby unavoidably “seeing what the tenants eat.” At one house, the idea of organizing part of the basement into a clubroom where tenants could relax out from under the gaze of staff also arose out of a concern for enhancing their privacy. Generally considered off-limits to all but house residents, the clubroom quickly became a popular alternative to the upstairs living area as a space for watching television, playing cards, or simply hanging out.

The clubroom is not the only space that is off-limits, however. Another is tenant bedrooms, which (save for exceptional circumstances) are entered only in the presence of the occupants, and then only with their explicit permission. All other rooms in the house are, however, accessible to tenants, including office space, traditionally the exclusive preserve of staff.

Thus, in seeking to give tenants a sense of home by maximizing their privacy, staff have in effect constrained their own movements. The effort to create as much private space for tenants as possible has resulted in twin injunctions to remain inside office space as much as possible and stay out of some areas of the house altogether. Whereas in the shelters staff can go anywhere but residents cannot, in the ECHs the

opposite is the case. In this instance practicing empowerment means inverting the politics of space that characterize shelter life.

Relationships: From Detachment to Involvement

The significance and need for space and privacy appear particularly salient for the mentally ill persons who inhabit urban streets and shelters. In an anthropological study of illness course in schizophrenia, Corin (1990) identifies a "distancing-and-relating" approach to social interaction as a factor in patients' ability to sustain independent living outside the psychiatric hospital. Individuals who adopt this approach choose to remain essentially detached from the social mainstream, but mitigate their detachment by moving in and out of public spaces — restaurants, shopping centers, city streets — which allow for minimal and anonymous contacts with others. These mediating spaces create an in-between reality in which one is simultaneously inside and outside the relational field — at a distance, but also part of a shared world. Corin interprets this style of sociability as a means of establishing relationships that can be successfully managed so as to avoid threats to fragile personal boundaries.

A similar distancing-and-relating style of sociability can be observed in shelter life. Many residents prefer to keep to themselves most of the time;⁶ yet many of these same individuals often seek the company of others in communal silence. Thus two residents often share the same table, smoking cigarettes, without contact or conversation.

When residents do strike up conversations, the exchanges often tend to be superficial and fleeting. One reason for this is that residents find it difficult, at times, to communicate meaningfully and in depth with their neighbors. When asked why this was so, one woman responded, "Would you want to have a conversation with someone who is talking to themselves, who is caught up with their *own* conversation?" While some individuals hear and respond to voices, others "talk ragtime," a slang reference to the tangential or illogical discourse of psychosis. These and other factors (the lack of privacy, the impermanence and anonymity of shelter life, the constant bartering for cigarettes and change) converge to define the shelter as, in the words of one woman, "not a place to make friends." "Everyone here has problems," she added. "Each goes their own individual way. So I have no real friends here." Other residents corroborated her remarks.

In fact, some residents prefer to live in the shelter precisely because it does *not* offer real friendships. "I think the shelter is the ideal situation for me," commented one woman. "Unlike a halfway house, there are enough people around that I don't feel the need to maintain deep ties with others, yet there are also enough people around that I don't get too lonely." This woman, who describes herself as having voluntarily dissociated herself from society when the state took away her child some twenty years ago, spends most of her time among others, reading the Bible, speaking little.

Shelter life offers this woman and others a way of being simultaneously inside and outside the social world. This style of relating may not be the preferred choice of all shelter residents, however. Some would apparently like to form closer relationships with their neighbors, but are prevented from doing so by the difficulties social interactions typically entail. "I have a good day as long as nobody bothers me," said one elderly man who sits alone at a table all day and is known for his gruff demeanor.

A preference for a detached style of sociability may, however, help to explain the initially negative reactions of many shelter residents when introduced to the idea of an ECH. Upon learning that they will be offered either group living or an "independen-

dent apartment" as part of the project, prospective participants often make it quite clear that they would prefer to live by themselves. The reported rationales for these preferences vary. Melissa, who suffered a nervous breakdown the last time she lived in a group home, felt that if she tried such an arrangement again it would be with the same result. Her inclination to try to "babysit" people and help them with their problems, together with her former housemates' frequent crises and suicide threats, caused her to become depressed. "I've had enough of group homes," she concluded.

Amy reported that she wanted to live alone, "not because of wanting to be haughty in my 'independence,' but because of necessity. I can't look at people." She went on to explain that she causes others to fall ill if she looks at them; therefore, she could not live in a house with others until her eyes got "better." Naomi at first refused her assignment to an ECH out of apprehension at the prospect of developing meaningful relationships with others, particularly men, whom she had known only superficially in the shelter. "They don't talk to me here," she complained, "so why should they talk to me there?" Despite such concerns, Naomi eventually decided to move into the house.⁷

Like other project participants, these three women initially preferred independent apartments because the stress and pressures they associated with group living did not, they felt, suit their best interests. These preferences seemed to reflect a combination of factors: a detached style of relating, personal choice, and a generally negative view of prior experiences with group homes run by the Department of Mental Health.

In making the transition to ECH living, residents leave the in-between reality of the shelter for an environment in which the establishment of meaningful associations with others is emphasized. No longer easily able to remain at a distance, ECH tenants are asked to acquire a group mentality and to learn effective group process as part of their preparation for independent living in the community. Staff repeatedly stress the development of a sense of community through "working together" as a key ingredient in a successfully functioning shared household. Working together may mean pooling financial resources to buy large quantities of supplies at cheaper prices; it may entail developing a system to ensure the equitable distribution of chores; or it may simply refer to collaboration on the planning and preparation of a group meal. Whenever possible, the tasks involved in maintaining a home are conceived and carried out as joint efforts.

Equally as important as developing a sense of community is learning to participate in the group process, which, in this context, means sharing responsibility and decision making. While tenants readily adhere to group decisions leading to greater physical comfort or fewer restrictions on their activities, their response is not consistently positive. "Freedom" appears to be accepted more easily than "responsibility."

For example, one principle of group process which has received considerable emphasis from staff is the idea that tenants should learn to "bring things up." To bring things up is to communicate negative feelings about another tenant's behavior directly to the individual involved. Staff tell tenants that, if someone is leaving dirty pots and pans in the sink, storing too much food in the refrigerator, or making enough noise to keep you awake at night, the way to deal with it is to speak to that person yourself, rather than relying on staff to intervene on your behalf. "This is a self-directed household," one staff person said at a weekly house meeting, "and while it is tempting to ask staff to take over and speak [to people for you], it really

isn't their place. This isn't like the shelter, where when you have a problem, it's the staff's job to solve it. Staff are here to help you learn to run the house. And that's why they can't be asked to step in."

Staff view the ability to bring things up as empowering because it will ideally enable tenants to solve interpersonal problems themselves once staff are no longer on site. Thus, being able to bring things up is seen as a form of both normalization and self-help.

Apprehensions about the implications of bringing things up do not excuse one from the exercise of this responsibility, since, in the words of one staff member, "The way this household is set up means that even if tenants are fearful they still need to speak up, because otherwise we're not teaching them what they need to know to be able to live in the community. If I take care of a situation for you, you haven't gotten anything out of it."

Staff efforts to impart a sense of community and skills in group process have been met with a generally unenthusiastic response. Tenants have made their preference for individuality, rather than community, known in a number of ways. One of the first to emerge was the decision to minimize joint purchases. After a lengthy discussion, only three items — paper towels, garbage bags, and toilet paper — were judged sufficiently generic to be bought with funds from the household kitty. Everything else, from food to toiletries to laundry soap, was assigned to the domain of personal choice.

The rejection of a system for sharing housework also seems to reflect a reluctance to develop group mentality. In one house, tenants have politely but consistently declined repeated suggestions that they distribute assigned tasks as a way of ensuring fairness in the division of household labor. They preferred to adopt an informal arrangement whereby each individual would "see something that needed to be done and do it."

Encouragement to bring things up to other tenants as part of learning group process has encountered similar resistance. A recovering alcoholic, for example, refrained from objecting to the consumption of alcohol in the house, even though he began drinking again as a result. Another individual chose to sleep in the living room rather than ask his neighbor to turn down the radio late at night.

The vehemence with which some tenants resist staff insistence that problems be brought up is illustrated by the following encounter. One individual steadfastly refused to bring up to a housemate the fact that he was finding a particular behavior objectionable, even though the perpetrator himself challenged him to do so and several staff were sitting nearby urging him on. "If you're talking to me, just tell me!" the heated exchange began. "If you've got a problem with *me*, confront *me*!" "I got nothin' to say to you. You don't run this place!" came the controlled but angry reply. "I take issues to staff. *They* run this place! If staff don't say nothin', *I* don't say nothin'!"

Tenants cite a number of reasons for not wishing to bring things up, most of which invoke the anticipated consequences of such an encounter. In their minds, these range in severity from hurt feelings and lost friendships to retaliation and resulting physical harm. Some express apprehension at becoming entwined in a complicated and painful interaction from which they fear they could not escape. Others feel that any efforts they made to effect change by bringing things up would simply fall on deaf ears. "Everybody will just do what they feel like doing anyway," explained one man. "If I say something no one believes me anyhow, so I got nothin' to say."

It is in the sense of being enjoined to think and behave as a member of a *group* that the transition from the shelter to the ECH household represents a transition from detachment to involvement in human relationships. Tenants' resistance to making the changes that will lead to such involvement — developing a sense of community, learning group process — attests to a certain discomfort with the process on their part. As one person put it, "I don't want to get too bound up with people. Getting too bound up with people is the wrong thing to do."⁸

Empowerment and Economics

The transition to ECH living brings with it new financial obligations. In the shelters, all food, rent, and program costs are borne by the Department of Mental Health. Tenants are free to spend or save their income, whose source is generally Social Security or General Relief. In the ECHs, however, tenants pay "rent" calculated at 30 percent of their income as a contribution toward the cost of maintaining the house.

Not only must tenants pay rent and buy food; they must also, as part of the empowerment process, begin the process of taking charge of their funds. In the domain of economics, the principles of normalization, knowledge, self-determination, *and* self-help converge in the premise that tenants should learn to think about and manage their money in ways that will allow them to live within their means.

One of the first challenges tenants face on arriving at the ECH residence is how to procure necessary food and supplies. Those with ready cash at their disposal simply make their way to the nearest convenience store to purchase a few basic necessities — coffee, soda, cigarettes, a TV dinner. This option is not available, however, to those whose financial arrangements leave them with only small amounts of pocket money under their control. Until their agreements can be renegotiated, these individuals are faced with the necessity of sustaining themselves by whatever means they can contrive.

In one ECH, this problem was somewhat alleviated by the fact that tenants with more money bought basic food items that they made available to the house. Without seeming concerned at the prospect of using their own meager resources for the benefit of perfect strangers, and without expecting to be paid back, these people purchased such items as coffee, milk, and sugar for general consumption.

When the time came, however, to organize the finances of the household in a more systematic way, one of the first issues to be raised by staff was that of reimbursing those members of the group who had made contributions to the household out of their personal funds. Allowing those with more to help tide over those with less was defined as a breach of fairness, "fairness" being defined in terms of the principle that people should not pay for what they do not use. Paying only for what you use is construed, in this instance, as a first step toward living within one's means.

A natural next step is learning to budget. Budgeting is considered one of the most powerful tools available to tenants as they work to establish both their personal independence and the financial solvency of the household. For this reason, staff make a point of modeling the budgeting process whenever an occasion arises.

A successful budget can be constructed in one of two ways. One can either begin with an assessment of obligations and needs, then allocate available funds so that as many as possible of those obligations and needs are fulfilled, or choose to start by

determining the total amount one has to spend and move from there to decisions about the distribution of funds. In either case, the point of the exercise is to avoid spending more than you have. It is in this sense that budgeting reflects the more basic principle of living within your means.

For staff, part of the task of guiding tenants toward an economics of empowerment is helping them unlearn spending practices that seem to be at variance with this goal. Tenants apparently bring to their new living situation their own, alternative principles of money management. Instead of living within one's means, theirs is an economics of reciprocity and spending down.

Tenants' willingness to purchase supplies for others until they can rearrange their finances after the move may be understood in these terms. In an economics of reciprocity, people provide for others what and when they can and, in return, expect others to provide for them if they should run short of resources. If tenants were quick to come to the aid of their fellows in need in the early days of the transition, it may have been because they are nice people, but it may also have been because they expected, given an economics of reciprocity, that the same would be done for them if the circumstances were reversed.

Giving when you have, in the context of an economics of reciprocity, becomes an investment in the future, a form of insurance against periodic, and inevitable, hard times. That this is how at least one tenant initially conceived of the household kitty is suggested by his references to it as a "system where we help each other. Not everyone will have enough for every day," he observed, "so you chip in when you can afford to. If you chip in, then you can use."

The principle of reciprocity also explains the economic style of one tenant who, on receiving his weekly shopping money, can be counted on to buy a large supply of groceries, a significant proportion of which he then offers to fellow tenants and staff. If, as is often the case, he runs out of food as a result, he bridges the gap to his next allotment by asking for, and receiving, contributions from other residents.

In contrast to budgeting, in which the primary objective is to avoid spending more money than one has, the spending-down approach to financing involves using the money one has to provide for *immediate* wants and needs. Rather than beginning with a calculation of the total amount one has to spend, and spreading that amount evenly, if thinly, over a specified period of time, those who spend down use as much of their money as it takes to make desired purchases at any given moment, without, it seems, worrying too much about the cost of those purchases or whether they will run out of cash. Here money is a means, not an end. In the spending-down approach to economics, the operating principle is to keep spending until it is gone.

The contrast between budgeting and spending-down approaches to money management clearly emerges in the following illustrative anecdotes.

In the first, a tenant embarked on his weekly grocery shopping accompanied by a staff member, whose assignment was to make some miscellaneous purchases for the house. Each had a limited amount of money to spend. The tenant had his two-week allotment of food stamps, half of which he was supposed to use that day, and half of which, according to his budget, was to be saved for the following week. The staff person had \$15 in cash.

On entering the supermarket, the tenant quickly moved to fill his carriage with goods, clearly knowing and seeing what he wanted and removing those items from the shelves. The staff member, however, hesitated, compared, calculated, replac-

ing goods deemed too expensive with cheaper brands. When the two arrived at the checkout, the tenant had spent nearly twice his one week's food allotment; the staff person had spent \$14.85. One had stayed within his means; the other had spent down.

The second anecdote involves Carol, a tenant, and Sue, one of the research team, who left one of the ECHs together to do a few errands. On the way back, Carol stopped to buy a lottery ticket. Having made the purchase, she turned to her companion and asked for the loan of some money to buy more. "How much do you want?" Sue asked. "Ten dollars" was the response. Swallowing hard, Sue politely refused.

An argument ensued as the two continued the walk home, with Carol accusing Sue of being cheap and Sue consistently denying the accusation. Carol seemed at a loss to understand why, since Sue had the money, she wouldn't lend it, since she would be sure to be paid back at the beginning of the month. Sue explained that she didn't like to spend so much cash at once. "I prefer," she said, "to use my money slowly." "My motto is, if you got it, you gotta spend it!" was Carol's laughing reply.

Though appearing dysfunctional at the outset, the principle of spending down begins to make sense when viewed in terms of the context in which homeless individuals, those who are homeless and mentally ill, and poor people in general live their daily lives. The notion of spending money immediately begins to be understandable, for example, when we remember that in street life, cash kept on hand is likely to be stolen, borrowed, or made to disappear in other ways. Not to be discounted, either, is the influence of Social Security Insurance, which forces people to spend down by jeopardizing the benefits of individuals who accumulate more than a stipulated amount of cash. Perhaps most important, however, are the effects of poverty, which seem to produce a type of seize-the-moment economic mentality. Budgeting and saving make little sense for those whose income is so inadequate to meet their expenses that they have lost all hope of ever getting ahead. Convinced that they will never be in a position to really afford a comfortable standard of living, they grab moments of pseudoprosperity by spending disproportionate amounts of their income on attractive, expensive, but pleasurable consumer goods. In spending down, tenants may be doing something similar.

The Golden Rule of Empowerment

The practice of empowerment as reflected in efforts to maximize tenant privacy, foster peer relationships, and help individuals learn to live within their means is grounded in what we might think of as the golden rule of staff-tenant relations in the ECHs. In making decisions about how to interpret a particular situation, or what action to take, staff regularly invoke an analogy to themselves, asking, "How would *I* feel?" or "What would *we* want?" if the circumstances were reversed? Thus the demonstration of respect for tenant privacy stems from an awareness of the value one places on one's own; the emphasis on community spirit and group process from staff definitions of the prerequisites for successful dealings with roommates, and the emphasis on not spending more than you have from the standards they set (but admittedly do not always adhere to) for their own behavior. The do-unto-tenants-as-you-would-do-for-yourself principle constitutes the golden rule of empowerment in this setting.

Implicit in the golden-rule approach to the implementation of empowerment is the assumption that "normalization" has the same meaning for those being empow-

ered as it does for those who conceptualize and manage the empowerment process. But is this in fact the case? The anthropological data presented here suggest that staff and tenants may have different conceptions of what normalization entails.

Tenants clearly attach great significance to the acquisition of privacy in making the transition to ECH living, and staff exercise considerable care to protect that privacy once the move has been made. This suggests that the essential role of privacy in establishing a "home" is agreed upon by both constituencies.

The impression of agreement begins to break down, however, when we consider the data on staff-tenant interactions in the areas of relationships and economics. We have seen, first, that tenants have so far tended to resist staff efforts to develop a community spirit among members of the household and impart the skills deemed necessary for effective group process. Evidence of differing philosophies of money management — staff's ethic of living within one's means versus an economics of reciprocity and spending down — also suggests that tenants have their own, alternative ways of arranging their affairs.

Highlighting those domains in which tenant preferences seem inconsistent with staff's inferences about those preferences leads us to the recognition that the golden rule of empowerment may not always apply. While for some issues, such as privacy, the assumption that staff and tenants share a common outlook would seem to be justified, in others acting on the basis of analogies to oneself may not be as empowering as it appears.

To the extent that the golden rule of empowerment proves to have limited applicability, it may be because the living-like-others definition of normalization is not one to which homeless mentally ill persons wholeheartedly subscribe. Alexander (1977) has pointed out the paradoxes that normalization practices pose for the chronically ill — by definition, one cannot be sick and "normal" at the same time. If tenants feel that the ways staff live their lives are of limited relevance to them, they may be expressing realistic doubts about just how normal they can be.

Beyond an aspiration to independent living and a determination to remain in comfortable, affordable housing outside psychiatric institutions, we do not yet know what the notion of normalization or living normally means for those who have agreed to become members of an ECH household. What we do know, and hope we have shown here, is that tenants have a definite and distinctive point of view, which they communicate clearly despite a demonstrated distaste for bringing things up. This point of view determines how they relate to their housemates and how they spend their money.⁹

The anthropological emphasis on privileging the insider's perspective is realized in this context as a rendering of staff as well as tenant points of view. Both may be legitimately construed as insiders. Their outlooks are in some ways similar, but in other ways inconsistent with each other.

This leads us to pose an anthropological question, which both sets the stage for further analysis and highlights the potential of ethnographic research to inform practice in this and other policy-relevant domains. Having documented discrepancies in the perspectives of empoweror and empoweree in the context of ECH living, we may next wish to consider what the implications of such discrepancies might be. Does the existence of an alternative, tenant point of view represent an obstacle to empowerment, or is its very presence a sign that empowerment is taking place? 🐼

Notes

1. The research on which this paper is based is supported by a grant to Harvard Medical School from the McKinney Research Demonstration Program for Homeless Mentally Ill Adults, Stephen M. Goldfinger, M.D., principal investigator. The McKinney program is administered by the National Institute of Mental Health.
2. ECH staff who accept positions in the residences do so with the understanding that they will eventually work themselves out of a job.
3. While tenants pay "rent" calculated as a percentage of their monthly income, the costs of operating the ECHs are subsidized by funds from the grant and the state Department of Mental Health. Subsidies will continue to be provided by the Department of Mental Health when the grant period ends.
4. For others, having a home involved, as well, a sense of family: "I ain't never had a home," one man, who spoke of a troubled childhood, told us. "Not even when I was a kid." When we then asked what made a home, the man replied, "My cousins seemed to have something there, being together, that I never had." Others reiterated this sense of a home as a place where people "stay together."
5. Abusive language and touching a staff member or a guest in particular ways are examples of inappropriate behavior.
6. Their preference further underscores the need for, and lack of, private spaces.
7. The ways this woman and other participants have changed their minds about group living are used as a rationale by project advocates when faced with resistance to the idea. As one staff person said to a man who voiced his reluctance to live with others, "Actually, a lot of [ECH tenants] didn't want to live with other people at first, but now they love it!"
8. As noted above, participants' preference for living independently suggests that this is a common sentiment in this group.
9. In making a case for a distinctive tenant point of view, we do not mean to imply that all tenants think the same way. Individuals differ, of course, in the ideas they espouse; here we are speaking at the level of the group.

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Program Design and Clinical Operation of Two National VA Initiatives for Homeless Mentally Ill Veterans

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In 1987, in response to reports of large numbers of veterans among America's homeless, the Department of Veterans Affairs established two new national health care initiatives, which have seen over 40,000 homeless veterans since their inception. We present here evaluation and treatment data on a sample of 14,000 of them. Because of differences in their design, the two programs vary in the degree to which they emphasize community outreach, homelessness prevention, and the provision of aftercare services to patients discharged from other VA programs. In spite of these differences, veterans treated in the two programs have similar health care problems and show similar degrees of improvement at the conclusion of residential treatment. About one third of those admitted complete residential treatment successfully; one third are known to be in stable community housing at the time of discharge; and more than one third are employed. These modest success rates reflect both the severity of psychiatric disorder and social dysfunction in this population, and the limited ability of health care programs to address the full range of problems faced by the homeless mentally ill, even when services are specifically tailored to meet their needs. In designing programs for the homeless, it is particularly important to link health care efforts directly with sustained vocational rehabilitation services, housing subsidies, and income supports. New VA initiatives in all three of these areas have been undertaken and are described.

Among the most prominent and sorrowful developments of the past decade was the emergence of a growing and increasingly visible population of homeless persons in virtually every major city in America.¹ The first accounts of this "new mendicancy" came from New York City in 1981,² but within a few years studies from dozens of cities had brought the poor health, deep poverty, and social alienation of the homeless to public attention.³

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Accounts of high prevalences of psychiatric illnesses among the homeless, at first based on casual observation,⁴ were subsequently confirmed by rigorously conducted surveys.⁵ Between one third and one half of the homeless suffer from serious psychiatric illnesses and half from substance-abuse disorders. Initially it was suggested that psychiatric illness itself, or at least the lack of available hospital treatment for psychiatric illness, was a major cause of homelessness. Others pointed out that it was the lack of appropriate community-based psychiatric care that left the mentally ill at risk for homelessness.⁶ By the end of the decade, however, most experts identified the declining availability of low-income housing and the increase in urban poverty as the prime *causes* of homelessness, and saw the mentally ill as among those most vulnerable to being caught in the squeeze between limited personal resources and high rents.⁷

Several early studies also made specific note of the substantial numbers of veterans of the U.S. armed forces among the homeless. By the end of 1989, sixteen studies had appeared, indicating that between 32 percent and 47 percent of homeless males were veterans,⁸ as compared to 29 percent of males in the general U.S. population.⁹ In view of the recent estimate by Wright¹⁰ of 500,000 homeless persons in America on an average night (about 80 percent of whom are males), it is possible that there are as many as 100,000 to 200,000 literally homeless veterans in America each night. It has been suggested in the popular press that the unexpectedly high proportion of veterans among the homeless might be explained by the presence of large numbers of psychologically scarred Vietnam combat veterans. A recent study, based on data from the programs described in this chapter, however, found that the age-adjusted proportion of Vietnam era and Vietnam theater veterans among the homeless is no greater than the proportion in the general veteran population. A plausible explanation for the large proportion of veterans among the homeless has yet to be suggested.

In 1987, the Veterans Administration — since renamed the Department of Veterans Affairs (VA) — like many other public health care systems, responded to the reports of severe health problems among the homeless by initiating two national health care initiatives: the forty-three-site Homeless Chronically Mentally Ill Veterans Program and the twenty-site Domiciliary Care for Homeless Veterans Program.¹¹ Located in thirty states and the District of Columbia, these programs assisted over 40,000 homeless veterans during their first four years of operation. We begin by comparing the design and implementation of these two programs, then review evaluation data on several thousand veterans to see if differences in program design are associated with differences between the programs in (1) the sociodemographic and clinical characteristics of the veterans evaluated; (2) the selection of patients for admission to residential treatment; and (3) veteran housing and vocational outcomes at the time of discharge. We also examine the ways in which the programs are similar to one another and, more generally, the role of specialized health care programs in addressing the burgeoning national crisis of homelessness.

Specialized Health Care Services

Experienced clinicians and health care planners have generally agreed that assisting homeless mentally ill persons is an immense clinical challenge and that both specialized health care services and residential treatment are essential parts of any effort on their behalf.¹² In 1985, the Robert Wood Johnson Foundation and the Pew Memorial Trust funded the Health Care for the Homeless (HCH) project, an influential nineteen-city demonstration program of community-oriented outreach services which

showed that *some* of the homeless would make use of health care services if they were delivered to them in the community.¹³ No residential component was included in the HCH program, and perhaps as a result, only half of all HCH patients were ever seen more than once. More recent studies that have examined the outcome of treatment programs for the homeless have suggested that clinical success requires a combination of clinical and residential services.¹⁴ Although many health care initiatives for the homeless have included a residential treatment or housing placement component, only a few have placed a major emphasis on direct provision of long-term housing.

Six service elements have been emphasized in published descriptions of innovative health care programs for the homeless mentally ill: mobile community outreach;¹⁵ provision of basic material resources;¹⁶ accessible psychiatric and medical care;¹⁷ assertive case management;¹⁸ residential rehabilitative treatment;¹⁹ and preventive efforts directed at keeping hospitalized mentally ill persons with inadequate housing resources from becoming homeless.²⁰ These elements have guided VA planners as they approached the challenge of developing new programs for homeless veterans.

The Two Initiatives

The Homeless Chronically Mentally Ill (HCMI) and Domiciliary Care for Homeless Veterans (DCHV) programs are based on five core clinical components: (1) community outreach; (2) clinical assessment; (3) psychiatric and medical treatment; (4) advocacy, case management, and linkage with VA and non-VA health care and social support services; and (5) provision of time-limited residential rehabilitation. While both programs offer each of these basic components to some degree, they have evolved somewhat different programmatic emphases. The HCMI program was designed to facilitate the entry of the often alienated homeless mentally ill veterans in the community into treatment. Its efforts center on community outreach by two-clinician teams who make contact with homeless veterans in shelters, soup kitchens, and on the streets; case management to link homeless veterans with health care and social services and to facilitate their continued access to those services; and residential treatment, provided through specially funded contracts with community providers.

The DCHV program, in contrast, places less emphasis on outreach and case management and provides its treatment and more emphasis on residential rehabilitation services on the grounds of VA medical centers. The DCHV program, in addition to treating veterans contacted through outreach, frequently accepts homeless veterans who are referred from other VA programs, providing them with preventive aftercare services. While both these programs have been described in previous publications²¹ a systematic comparison of their origins and operation, and a general consideration of the role of health care programs in the overall effort to assist the homeless mentally ill, has not yet appeared. The study of these programs is greatly facilitated by the fact that they were evaluated with a common set of instruments and procedures, by a single evaluation team at VA's Northeast Program Evaluation Center (NEPEC).

Program Design and Implementation

The HCMI and DCHV programs were designed and implemented under the leadership of VA Central Office (VACO) officials of the Veterans Health Administration of the Department of Veterans Affairs.²² Each program was shaped by its legislative

background, historical traditions and recent trends within the specific VACO services responsible for their implementation, the expected duration of funding at the time of program implementation, and the nature of the designated residential treatment resources.

Legislative Bases

Both the HCMI program and the DCHV program were initiated in 1987 through legislation passed during the 100th Congress. The legislation that funded the HCMI program (Public Law 100-6) authorized a program that would provide time-limited residential treatment for homeless chronically mentally ill veterans through contracts with non-VA providers. Contract residential treatment was specifically identified in the legislation as an alternative to hospital care, reflecting a growing congressional interest in encouraging community-based approaches to VA mental health care. The DCHV program was established by Public Law 100-71, which called on the VA to identify "underutilized space located in VA facilities in urban areas in which there are significant numbers of homeless veterans" to be allocated for the care of the homeless.

The emphasis of both programs was thus on assisting the homeless through provision of time-limited residential rehabilitation and treatment. The principal difference in their legislative foundations was that in the HCMI program, residential treatment was to be provided through contracts with non-VA facilities, while in the DCHV program, residential treatment would be located in underutilized space on the grounds of existing VA medical centers. In their legislative origins, therefore, the HCMI program had a distinctive community orientation, while the DCHV program, as a result of its physical location, was associated with other programs operating within the same medical center.

Historical Traditions and Recent Trends in Implementing VA Services

Implementation of the HCMI program was the responsibility of VA's Mental Health and Behavioral Sciences Service (MH&BSS). Directed by a psychiatrist, the MH&BSS bears responsibility for oversight and planning of all VA mental health programs. Implementation of the DCHV program, in contrast, occurred under the leadership of the chief of Domiciliary Care Programs, an experienced health care administrator with mental health program management background, working in VA's Geriatric and Extended Care Service. Traditions and trends in these services are somewhat different and further shaped the emphases of the two programs.

The HCMI program and VA mental health care. The principal development in VA mental health care, during the past 30 years, as in other public mental health systems, has been the shift in the locus of care from hospitals to the community. Between 1956 and 1989, the number of VA psychiatric inpatients declined from 63,000 to 21,000, and there were major increases in the provision of psychiatric outpatient treatment, day treatment, and foster care. Concern about the quality of life of the "deinstitutionalized" mentally ill in MH&BSS, as elsewhere, has grown in recent years and led to renewed efforts to provide comprehensive community-based assistance through community support programs, intensive case management, structured rehabilitation programs, time-limited residential rehabilitation, and supported housing. The design of the HCMI program reflects these interests

in its emphasis on outreach, community-based case management, and community-based residential rehabilitation.

The DCHV program and VA Geriatric and Extended Care Service. The DCHV program builds on a century-old VA tradition of providing care to homeless, frequently elderly veterans with either psychiatric or medical disabilities. The first domiciliaries were established in the late nineteenth century²³ to provide long-term care to disabled veterans of the Civil War. Since that time, the VA Domiciliary Care program, which now includes over 8,000 beds, has provided often lifelong residential and health care service to thousands of veterans, many of whom have been homeless.

Since the mid-1980s, however, the Domiciliary Care program, consistent with the overall thrust of extended care services in VA, has been moving away from its "old soldier's home" traditions and toward a more active treatment model. In 1983, a formal Mission Clarification Statement urged a clinical focus on bio-psycho-social rehabilitation in VA domiciliaries and emphasized the objective of preparing veterans for community reentry. As pressure to reduce hospital lengths of stay mounted after implementation of the VA's Diagnosis Related Group-based Resource Allocation Model in 1984,²⁴ domiciliaries were increasingly used by medical center managers to facilitate discharge and community reentry from acute inpatient programs.

In keeping with this background, the DCHV program evolved as a medical center-based initiative, emphasizing aftercare and social and vocational rehabilitation. Outreach and sustained community-based care, while conducted at most sites, were secondary features, and the primary emphasis was placed on developing effective therapeutic milieus at each site.

Resources

In addition to differences in their legislative mandates and the traditions and trends of the services responsible for their implementation, the HCMI and DCHV programs also differed in their initial funding time frames and in the residential resources available to them.

Duration of funding. The HCMI program was initially funded on an emergency basis, with \$5 million for only six months of operation. Although the program was eventually funded on a recurring basis at almost \$13 million per year, at the time of its implementation the program faced the prospect of being a short-lived effort. Because of the need for rapid implementation, and possibly an equally rapid dismantling of the program, a large number of sites (43) were funded, each with a small staff and a modest budget for residential treatment. Since residential treatment in the HCMI program is paid on a per diem basis, the number of contract beds at each site would not influence the unit cost of service, and economies of scale were not considered in determining funding levels at each site. On average, each HCMI site supports sixteen veterans per day in residential treatment at three different residential treatment facilities per site.

Although the DCHV program was also initially funded on a nonrecurring basis, it, unlike the HCMI program, was implemented with the explicit expectation that it would eventually receive recurring operational funds at about the same level as the HCMI program, \$10.4 million per year, with an additional one-time allocation of \$4.5 million for building renovation. The DCHV program was to be entirely staffed and supported by VA, without contracts with non-VA providers. To maximize cost

efficiency, each domiciliary included at least forty operational beds. Ten DCHV sites were located at sites where no domiciliary program had previously existed ("new" sites), at which forty to seventy-five beds were planned. Ten additional DCHV programs were planned for medical centers that already supported domiciliaries ("established" sites). At these, only twenty-five DCHV program beds were projected, on the assumption that these sites would draw clinical and administrative support from the existing domiciliary, as well as from the parent VA medical center.

Table 1

**Program Sites and Their Standardized Metropolitan
Statistical Area (SMSA) Populations,
HCMV Veterans Program and DCHV Program**

HCMV Veterans Program		DCHV Program	
New York, NY	9,120,346	Brooklyn, NY	9,120,346
Long Beach, CA	7,477,503	West Los Angeles, CA	7,477,503
Los Angeles (OPC), CA	7,477,503	Cleveland OH	1,898,825
West Los Angeles, CA	7,477,503	Portland, OR	1,242,594
San Francisco, CA	3,250,630	Milwaukee, WI	1,389,000
Washington, DC	3,060,922	Dayton, OH	830,070
Houston, TX	2,905,353	Little Rock, AR	393,774
Boston, MA	2,763,357	Hampton, VA	364,449
St. Louis, MO	2,356,460	American Lake (Tacoma), WA	158,501
Pittsburgh, PA	2,263,894	Palo Alto, CA	< 100,000
Atlanta, GA	2,029,710	North Chicago, IL	< 100,000
San Diego, CA	1,861,846	Lyons, NJ	< 100,000
Denver, CO	1,620,902	Coatesville, PA	< 100,000
Tampa, FL	1,569,134	Montrose, NY	< 100,000
Phoenix, AZ	1,509,052	Bay Pines, FL	< 100,000
Cincinnati, OH	1,401,491	Hot Springs, SD	< 100,000
Kansas City, MO	1,327,106	Biloxi, MS	< 100,000
Buffalo, NY	1,242,826	Leavenworth, KS	< 100,000
Portland, OR	1,242,594	White City, OR	< 100,000
New Orleans, LA	1,187,073	Mountain Home, AR	< 100,000
Indianapolis, IN	1,166,575		
San Antonio, TX	1,071,954		
Salt Lake City, UT	936,255		
Louisville, KY	906,152		
Nashville, TN	850,505		
Dayton, OH	830,070		
Syracuse, NY	642,971		
Wilkes-Barre, PA	635,481		
East Orange, NJ	556,972		
Tucson, AZ	531,443		
Mountain Home, TN	433,638		
Charleston, SC	430,462		
Little Rock, AR	393,774		
Hampton, VA	364,449		
Augusta, GA	327,372		
Bath (Rochester), NY	< 100,000		
Walla Walla, WA	< 100,000		
Cheyenne, WY	< 100,000		
Roseburg, OR	< 100,000		
Tuskegee, AL	< 100,000		
Perry Point, MD	< 100,000		
Hines, IL	< 100,000		

Residential treatment resources and site location. The nature of residential resources available to each program also had a significant influence on program development, particularly in the location of program sites. HCMI sites were most often located in large cities where non-VA community residential treatment programs were well established, and many were located in or near neighborhoods where the homeless congregate. Over half (51%) of HCMI sites are in standard metropolitan statistical areas (SMSAs) of over one million population, and only 16 percent are in cities of fewer than 100,000 (Tables 1 and 2). In the late 1980s, a time of declining budgets for mental health services in many urban localities, residential treatment facilities were often eager to establish contracts with VA.

Table 2

**Distribution of Program Sites by SMSA Size:
HCMI and DCHV Programs**

SMSA Size	HCMI		DCHV	
> 2,000,000	11	25.6%	2	10.0%
1,000,000 to 2,000,000	11	25.6%	3	15.0%
100,000 to < 1,000,000	14	32.6%	4	20.0%
< 100,000	7	16.3%	11	55.0%
Total	43	100.0%	20	100.0%

Since space at VA medical centers located in urban areas was usually fully committed, most of these hospitals lacked space in which to locate DCHV programs. As a result, the majority of DCHV programs were located in rural or suburban locations, at medical centers that, before deinstitutionalization, had housed large psychiatric populations and therefore had ample underutilized space. Only 25 percent of DCHV sites are located in SMSAs over one million, and 50 percent are in cities of fewer than 100,000 (Tables 1, 2). Differences in geographic locality may also have contributed to the different clinical emphases of the two programs. The fact that DCHV programs were often located at some distance from large concentrations of the homeless may also have led them to focus their attention on homeless veterans who had come to the medical center for acute medical or psychiatric treatment.

Similar as they are in many of their basic clinical components and objectives, the HCMI and DCHV programs differed in several important ways. While the HCMI program was oriented toward both identifying and treating alienated, underserved homeless veterans in urban community settings, the DCHV program was designed to be more medical center focused, providing rehabilitative care to veterans who had recently completed other VA programs; helping them sustain clinical gains; and preventing their return to homelessness. These differing emphases reflect a multiplicity of internal and external forces, including different legislative origins, contrasting traditions and agendas of their implementing services, and specific features of their financial and residential resource bases. It is particularly noteworthy that the differences between the programs did not arise out of any explicit plan to establish a diversity of programs for homeless veterans, nor out of any sense that the two programs might serve contrasting subgroups of homeless veterans with different needs.

Similarities between the two programs are as noteworthy as their differences. Both programs were essentially health care programs, whose main mission is the treatment of illness on an individual basis. They were only secondarily concerned with solving individual housing and income programs, and had virtually no responsibility for addressing the larger societal processes that many feel are the root cause of homelessness.²⁵

Veteran Characteristics and Selection for Admission

In this section and the next our attention turns to evaluation data on the clinical operation of the HCMV and DCHV programs, specifically to a comparison of characteristics of veterans they assessed (including those not admitted to residential treatment); characteristics of those who were admitted to residential treatment; the influence of various veteran characteristics on the likelihood of admission to residential treatment; and the outcome of residential treatment at the time of discharge.

Methods

Data gathering procedures. During the first year of operation (May 1987–March 1988 for the HCMV program; November 1988–November 1989 for the DCHV program) patient-specific data reflecting the clinical operation of the two programs were collected in three phases. At the time of initial contact with each program, veterans were assessed with a standardized interview form. Those who were admitted to residential treatment were further assessed with a more detailed evaluation battery. Finally, at the end of each episode of residential treatment, a structured discharge summary was completed.

Training sessions in the proper use of the forms were held with representatives from each site. On completion, each form was individually reviewed for completeness and consistency by staff at NEPEC. Anomalous or inconsistent responses were checked, by phone, with staff members from the site.

Instruments. The Intake Form for Homeless Veterans (IFHV) documents basic sociodemographic data, past psychiatric and substance-abuse hospitalization, and current self-reported psychiatric, medical, alcohol, and drug problems. A ten-item Psychiatric Problem Index (PPI), based on three self-report items and seven clinician observations, is used to identify non-substance-abuse psychiatric problems. On a sample of 1,318 veterans from the HCMV program, a score of 2 or more on the PPI was associated with the presence of a major psychiatric disorder (schizophrenia, affective disorder, for example) as determined by a psychiatrist's clinical examination, with a sensitivity of 80 percent and a specificity of 58 percent.

The IFHV also documents receipt of disability payments, the duration of the current episode of homelessness, residence at the time of the IFHV assessment, the mode of first contact with the program, and the veteran's level of interest in services offered.

The evaluation battery completed at the time of admission to residential treatment provides more detailed information concerning past homelessness, educational background, marital status, current and past employment, current income, criminal history, length of residence in the current city (an indicator of residential transience), health service utilization during the previous six months, and several additional psychiatric symptoms.

The standardized discharge summaries document the length of stay in residential treatment, employment status, housing status at the time of discharge, and the primary reason for discharge, that is, successful completion of the program, dropped out, asked to leave for violating program rules, transferred to another institutional program, or other.

Analysis. The statistical significance of differences in the proportions of veterans with various characteristics in the two programs was evaluated using the 95 percent confidence interval of differences between proportions. To determine veteran characteristics independently associated with admission to residential treatment in each program, logistic regression analyses were conducted in which admission was the dependent variable and various veteran characteristics were independent variables.

Characteristics of Veterans Assessed

Number of veterans assessed. Altogether 10,524 veterans were assessed by the HCMI veterans program during the ten-month evaluation period (245 per site) as compared to 4,063 veterans in the first twelve months of the DCHV program (203 per site). This difference reflects the relative emphasis on outreach and case management services, in addition to residential treatment, in the HCMI program.

Demographic characteristics. Veterans assessed by the two programs were similar in gender but slightly different in age and race. Those assessed in the HCMI program were somewhat younger than those assessed by the DCHV program (Table 3) and more likely to be black or Hispanic, most likely because HCMI program sites were more often located in densely populated urban areas with larger minority populations. Both programs, however, contacted large percentages of minorities, a well-documented characteristic of homeless populations across the country.²⁶

Table 3

Characteristics of All Homeless Veterans Assessed by the HCMI Veterans Program and the DCHV Program, Including Those Not Admitted to Residential Treatment

	HCMI Veterans Program N = 10,524	DCHV Program N = 4,063	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference		
Age						
< 35	26.5%	22.1%	4.4%	2.9%	-	5.9%
35-44	37.0%	40.5%	-3.5%	-5.2%	-	-1.7%
> 44	36.5%	37.4%	-0.9%	-2.7%	-	0.8%
Total	100.0%	100.0%				
Gender						
Male	98.6%	98.0%	0.7%	0.2%	-	1.2%
Female	1.4%	2.0%	-0.7%	-1.2%	-	-0.2%
Total	100.0%	100.0%		0.0%	-	0.0%
Ethnicity						
White	58.2%	65.6%	-7.4%	-9.1%	-	-5.6%
Black	33.6%	29.1%	4.5%	2.8%	-	6.1%
Hispanic/other	8.2%	5.3%	2.9%	2.0%	-	3.8%
Total	100.0%	100.0%				

Table 3, continued

	HCMI Veterans Program N = 10,524	DCHV Program N = 4,063	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference	
Mode of First Contact					
Outreach	56.8%	18.1%	38.8%	37.2%	- 40.3%
Came to VA (any)	24.5%	74.2%	-49.7%	-51.2%	- -48.1%
Other	18.6%	7.7%	10.9%	9.8%	- 12.0%
Total	100.0%	100.0%			
Current Residence					
Apartment, room, house	15.4%	20.6%	-5.2%	-6.6%	- -3.8%
Shelter or no residence	75.9%	41.6%	34.3%	32.6%	- 36.0%
Institution	8.7%	37.8%	-29.1%	-30.6%	- -27.5%
Total	100.0%	100.0%			
Duration of Homelessness					
Not homeless-1 month	24.8%	43.3%	-18.4%	-20.1%	- -16.7%
1 month-1 year	43.3%	37.9%	5.3%	3.6%	- 7.1%
> 1 year	31.9%	18.8%	13.1%	11.6%	- 14.6%
Total	100.0%	100.0%			
Past Hospitalization (Any)					
Past psychiatric hospitalization	33.1%	36.2%	-3.1%	-4.8%	- -1.4%
Past alcohol hospitalization	44.2%	59.1%	-14.9%	-16.7%	- -13.2%
Past drug hospitalization	15.5%	25.7%	-10.2%	-11.7%	- -8.6%
VA Hospital, Past 12 Months	38.4%	68.7%	-30.3%	-32.0%	- -28.6%
Psychiatry	19.4%	29.5%	-10.1%	-11.7%	- -8.5%
Substance abuse	16.3%	29.5%	-13.1%	-14.7%	- -11.6%
Medical	13.2%	21.0%	-7.7%	-9.1%	- -6.3%
Surgical	5.3%	7.2%	-2.0%	-2.8%	- -1.1%
Intermediate medical	1.8%	4.0%	-2.2%	-2.8%	- -1.6%
Financial Support					
Service connected (medical or psychiatric)	12.7%	16.5%	-3.8%	-5.1%	- -2.5%
Any public support	51.6%	34.3%	17.3%	15.6%	- 19.0%
Current Health Problems					
Psychiatric problems	43.0%	38.1%	4.9%	3.1%	- 6.6%
Alcohol problems	49.4%	55.0%	-5.6%	-7.4%	- -3.8%
Drug problems	16.8%	17.7%	-0.8%	-2.2%	- 0.6%
Dual diagnosis (psychiatric/ substance abuse)	23.6%	17.6%	6.0%	4.5%	- 7.4%
Chronic medical problems	53.3%	53.9%	-0.6%	-2.4%	- 1.2%
Serious medical problems	46.2%	42.8%	3.4%	1.6%	- 5.1%
Treatment Needs					
Mental health Rx	33.0%	36.1%	-3.1%	-4.8%	- -1.4%
Detoxification	19.1%	5.4%	13.7%	12.7%	- 14.7%
Substance-abuse Rx	47.4%	40.4%	7.0%	5.2%	- 8.8%
Interest in Services					
Doesn't want services	21.6%	2.2%	19.4%	18.4%	- 20.3%
Wants all services	70.6%	91.5%	-20.9%	-22.1%	- -19.6%
Other	7.8%	6.3%	1.5%	0.6%	- 2.4%

Mode of first contact. Consistent with the different clinical emphases of the two programs, the greatest difference between the HCMI and DCHV programs was in the mode of first contact with veterans (Table 3). Over half (57%) of veterans assessed by the HCMI program were contacted through outreach, only 25 percent came to VA programs on their own (either self-referral or referred from another VA program), and 19 percent came through other routes. In contrast, in the DCHV program, 74 percent came to VA on their own, 18 percent were contacted through outreach, and 8 percent through other routes.

It is notable, however, that, in spite of the HCMI program's specific emphasis on outreach, 43 percent of those assessed in it were contacted through routes other than outreach. Both programs became well known among the homeless in their areas, and eventually veterans began to seek assistance from them on their own, independently of any outreach efforts. The HCMI program, like the DCHV program, was also rapidly identified by other VA medical center programs as a potential aftercare resource for homeless veterans completing acute care programs. Some HCMI sites made special efforts to preserve the community outreach orientation of the program, which might otherwise been used almost exclusively to facilitate the transition of homeless inpatients to the community.

Residential status and duration of homelessness. Substantial differences were also apparent between the two programs in the veterans' current residences and the duration of their current episodes of homelessness. Compared to those assessed by the DCHV program, a greater percentage of veterans assessed by the HCMI program were living in a shelter or were without any residence at the time of assessment (76% versus 42%) and a smaller percentage were residing in an institution (9% versus 38%). In addition, HCMI veterans were more likely to have been homeless for over one year (32% versus 19%), while a smaller percentage of veterans had been homeless for less than one month or were at risk for homelessness but not homeless at present (25% versus 43%). These differences are probably related to the differences in the mode of first contact.

Past hospitalization and financial support. Veterans assessed in the HCMI program were somewhat less likely than veterans assessed in the DCHV program to ever have been hospitalized in the past, at either a VA or non-VA hospital, for psychiatric, alcohol, or drug problems (Table 3). Furthermore, 30 percent fewer veterans assessed in the HCMI program had been hospitalized at a VA facility during the twelve months prior to assessment (Table 3). When recent hospitalization is examined by type of problem, veterans in the HCMI program are observed to be especially less likely than those in the DCHV program to have been hospitalized in VA psychiatric (10 percent fewer than in the DCHV program) or substance-abuse programs (13 percent fewer than in the DCHV program). In contrast to the substantial differences in both past and recent hospitalization, much smaller differences are apparent in the percentages of veterans receiving either VA service-connected or non-VA public support payments like Social Security and welfare.

Current health problems. Only modest differences were noted between veterans assessed in the two programs in the frequency of current mental and physical health problems. Altogether, 5 percent more veterans assessed in the HCMI program had psychiatric problems (43% versus 38%), 6 percent fewer had alcohol problems (49% versus 55%) and 6 percent more had both psychiatric and substance-abuse problems (24% versus 18%). While these differences are statistically significant, they are not

of major clinical or programmatic importance. It is also striking that the prevalence of medical problems was similar in the two programs (Table 3).

Service needs. Differences between the two programs in the clinicians' assessments of the need for mental health or substance-abuse treatment were also modest (Table 3). It is notable, however, that 14 percent more veterans assessed in the HCMI program were felt to need detoxification, presumably because those contacted in the community were more likely to be acutely chemical dependent, and because DCHV veterans were more likely to have received detox services.

Veterans' interest in services. A final, and quite striking, contrast is that a substantially greater percentage of veterans assessed in the HCMI program were reported by the evaluating clinician to be uninterested in services (22% versus 2%), either because they did not want any assistance (8.3%) or because they wanted only basic material services and not the treatment provided by the program (13.2%). This finding is particularly salient in view of the apparent similarity in clinical problems and clinically assessed need for services among veterans evaluated by the two programs. Veterans contacted through outreach appear less likely than others to feel a need for the services they are offered.

Characteristics of Veterans Admitted to Residential Treatment

Altogether, 20 percent (2,115) of veterans assessed by the HCMI veterans program were admitted to residential treatment, as compared to 55 percent (2,237) of those assessed by the DCHV program. The lower admission rate in the HCMI program reflects, once again, its dual focus both on providing contract residential treatment and on community outreach and case management services.

When the characteristics of veterans admitted to contract residential treatment in the HCMI program are compared with the characteristics of those admitted to the DCHV program, the contrasts noted in the previous section are still apparent, but their magnitude is substantially reduced (Table 4). Veterans admitted to residential treatment in the HCMI program were still considerably more likely to have been contacted through outreach (49% versus 11%) and less likely to be living in an institution (15% versus 44%) than those admitted to the DCHV program.

Table 4

Characteristics of Veterans Admitted to Residential Treatment in the HCMI Veterans Program and in the DCHV Program

	Admitted to HCMI Residential Treatment N = 2,115	Admitted to DCHV Residential Treatment N = 2,237	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference		
Age						
< 35	24.7%	22.1%	2.6%	0.1%	-	5.2%
35-44	40.0%	42.7%	-2.6%	-5.6%	-	0.3%
> 44	35.3%	35.3%	0.0%	-2.9%	-	2.9%
Total	100.0%	100.0%				
Gender						
Male	98.6%	97.9%	0.7%	-0.1%	-	1.5%
Female	1.4%	2.1%	-0.7%	-1.5%	-	0.1%
Total	100.0%	100.0%				

Table 4, continued

	Admitted to HCMV Residential Treatment N = 2,115	Admitted to DCHV Residential Treatment N = 2,237	HCMV- DCHV Difference	95% Confidence Interval of HCMV-DCHV Difference		
Ethnicity						
White	59.9%	66.6%	-6.7%	-9.6%	-	-3.8%
Black	33.2%	28.1%	5.1%	2.3%	-	7.9%
Hispanic/other	6.8%	5.3%	1.6%	0.1%	-	3.0%
Total	100.0%	100.0%				
Mode of First Contact						
Outreach	48.7%	11.4%	37.2%	34.7%	-	39.8%
Came to VA (any)	26.7%	80.0%	-53.3%	-55.8%	-	-50.7%
Other	24.6%	8.6%	16.1%	13.8%	-	18.3%
Total	100.0%	100.0%				
Current Residence						
Apartment, room, house	10.4%	16.8%	-6.4%	-8.5%	-	-4.4%
Shelter or no residence	74.5%	39.4%	35.1%	32.4%	-	37.9%
Institution	15.1%	43.8%	-28.7%	-31.3%	-	-26.2%
Total	100.0%	100.0%				
Duration of Homelessness						
Not homeless-1 month	20.8%	39.7%	-18.9%	-21.6%	-	-16.2%
1 month-1 year	48.5%	40.5%	8.0%	5.0%	-	11.0%
> 1 year	30.7%	19.8%	10.9%	10.9%	-	10.9%
Total	100.0%	100.0%				
Past Hospitalization (Any)						
Past psychiatric hospitalization	42.0%	35.2%	6.7%	3.8%	-	9.7%
Past alcohol hospitalization	55.0%	60.1%	-5.1%	-8.1%	-	-2.1%
Past drug hospitalization	19.6%	28.1%	-8.5%	-11.0%	-	-6.0%
VA Hospital, Past 12 Months						
Psychiatry	57.7%	71.2%	-13.4%	-16.3%	-	-10.6%
Substance abuse	29.8%	30.0%	-0.2%	-2.9%	-	2.6%
Medical	28.2%	43.6%	-15.4%	-18.2%	-	-12.6%
Surgical	17.0%	20.5%	-3.6%	-5.9%	-	-1.2%
Intermediate medical	7.5%	6.8%	0.7%	-0.9%	-	2.2%
Intermediate medical	2.2%	3.4%	-1.2%	-2.2%	-	-0.2%
Financial Support						
Service connected (medical or psychiatric)	12.5%	15.3%	-2.8%	-4.9%	-	-0.8%
Any public support	36.2%	34.3%	1.9%	-1.0%	-	4.8%
Current Health Problems						
Psychiatric problems (2)	50.2%	37.5%	12.8%	9.8%	-	15.7%
Alcohol problems	51.9%	55.0%	-3.1%	-6.1%	-	-0.1%
Drug problems	18.0%	18.0%	-0.0%	-2.3%	-	2.3%
Dual diagnosis (psychiatric/ substance abuse)	27.1%	16.4%	10.6%	8.2%	-	13.1%
Chronic medical problems	52.6%	52.1%	0.5%	-2.5%	-	3.5%
Serious medical problems	45.2%	41.9%	3.2%	0.3%	-	6.2%
Treatment Needs						
Mental health Rx	76.4%	49.8%	26.6%	23.9%	-	29.4%
Detoxification	14.7%	3.1%	11.6%	9.9%	-	13.4%
Substance-abuse Rx	52.1%	42.0%	10.2%	7.2%	-	13.2%
Interest in Services						
Doesn't want services	5.9%	0.9%	5.0%	3.9%	-	6.1%
Wants all services	90.8%	94.7%	-3.9%	-5.5%	-	-2.4%
Other	3.3%	4.4%	-1.1%	-2.2%	-	0.1%

More extensive data were gathered on veterans admitted to residential treatment in the two programs, permitting further examination of their similarities (Table 5). Remarkably, for the majority of variables on which data are available, differences between veterans admitted to residential treatment in the two programs are not statistically significant.

Table 5

Supplementary Admission Data on Veterans Admitted to Residential Treatment in HCMI and DCHV Programs

	Admitted to HCMI Residential Treatment N = 1,468 (69.4%)	Admitted to DCHV Residential Treatment N = 2,009 (89.8%)	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference		
Marital Status						
Married/widowed	6.6%	7.5%	-0.9%	-2.6%	—	0.8%
Separated	15.7%	16.5%	-0.8%	-3.3%	—	1.6%
Divorced	46.1%	47.3%	-1.2%	-4.5%	—	2.2%
Never married	31.6%	28.6%	2.9%	-0.2%	—	6.0%
Total	100.0%	100.0%				
Education (years)						
0-8	5.7%	4.0%	1.7%	0.2%	—	3.1%
9-11	11.8%	12.1%	-0.2%	-2.4%	—	1.9%
12	49.4%	46.6%	2.7%	-0.6%	—	6.1%
13-16	31.3%	34.3%	-3.1%	-6.2%	—	0.1%
>16	1.8%	2.9%	-1.1%	-2.1%	—	-0.1%
Total	100.0%	100.0%				
Usual Employment (Past 3 Years)						
Full time	32.6%	34.0%	-1.4%	-4.6%	—	1.7%
Part time	34.5%	31.8%	2.8%	-0.4%	—	5.9%
Retired/disabled	5.9%	5.8%	0.1%	-1.4%	—	1.7%
Unemployed	24.4%	24.9%	-0.5%	-3.4%	—	2.4%
Other	2.5%	3.5%	-1.0%	-2.1%	—	0.2%
Total	100.0%	100.0%				
Total Income (Past 30 Days)						
None	34.4%	36.3%	-1.9%	-5.1%	—	1.3%
\$1-99	19.8%	20.6%	-0.8%	-3.5%	—	1.9%
\$100-499	37.2%	33.8%	3.5%	0.2%	—	6.7%
>\$499	8.5%	9.4%	-0.8%	-2.7%	—	1.1%
Total	100.0%	100.0%				
Earned Income (Past 30 Days)						
None	71.6%	76.9%	-5.4%	-8.3%	—	-2.4%
\$1-99	11.3%	9.1%	2.2%	0.1%	—	4.2%
\$100-499	14.1%	11.7%	2.4%	0.2%	—	4.7%
>\$499	3.0%	2.3%	0.7%	-0.3%	—	1.8%
Total	100.0%	100.0%				
Now on Probation or Parole	10.5%	9.8%	0.7%	-1.4%	—	2.7%
Number of Crimes Arrested For						
None	48.9%	49.2%	-0.3%	-3.7%	—	3.0%
1-3 crimes	44.4%	42.5%	1.9%	-1.5%	—	5.2%
>3 crimes	6.7%	8.2%	-1.5%	-3.3%	—	0.2%
Total	100.0%	100.0%				

Table 5, continued

	Admitted to HCMV Residential Treatment N = 1,468 (69.4%)	Admitted to DCHV Residential Treatment N = 2,009 (89.8%)	HCMV- DCHV Difference	95% Confidence Interval of HCMV-DCHV Difference	
Years Lived in This City					
6 months or less	25.3%	28.8%	-3.5%	-6.4%	-0.5%
1-2 years	8.4%	7.3%	1.1%	-0.7%	2.9%
> 2-5 years	14.3%	12.0%	2.3%	-0.0%	4.6%
> 5-10 years	9.3%	8.7%	0.5%	-1.4%	2.5%
> 10 years	42.7%	43.2%	-0.5%	-3.8%	2.9%
Total	100.0%	100.0%			
First Time Homeless?	51.2%	54.3%	-3.2%	-6.5%	0.2%
Episodes of Homelessness (Life)					
None	10.6%	13.6%	-2.9%	-5.1%	-0.8%
1-2 episodes	54.1%	60.9%	-6.8%	-10.1%	-3.5%
3-5 episodes	19.0%	14.2%	4.8%	2.2%	7.3%
6-10 episodes	9.2%	6.0%	3.2%	1.4%	5.0%
> 10 episodes	7.1%	5.3%	1.8%	0.1%	3.4%
Total	100.0%	100.0%			
Violence Is Current Problem	13.7%	7.9%	5.8%	3.6%	7.9%
Suicide Attempt (Past 30 Days)	4.1%	1.4%	2.7%	1.5%	3.8%
VA Outpatient Visits, Past 6 Months					
None	51.4%	44.8%	6.6%	3.3%	10.0%
1-3 visits	25.1%	27.2%	-2.2%	-5.1%	0.8%
>3 visits	23.5%	28.0%	-4.4%	-7.4%	-1.5%
Total	100.0%	100.0%			
VA Mental Health or Substance- Abuse Outpatient Visits (6 Months)					
None	79.4%	40.0%	39.4%	36.5%	42.4%
1-3 visits	11.0%	16.1%	-5.1%	-7.4%	-2.8%
>3 visits	9.6%	43.9%	-34.3%	-37.0%	-31.7%
Total	100.0%	100.0%			
Lifetime Psychiatric Hospitalizations					
None	56.6%	62.7%	-6.1%	-9.4%	-2.8%
1-2	19.8%	21.2%	-1.4%	-4.1%	1.3%
3-5	12.1%	8.8%	3.4%	1.3%	5.4%
6-10	6.3%	4.6%	1.6%	0.1%	3.2%
> 10	5.1%	2.6%	2.5%	1.2%	3.8%
Total	100.0%	100.0%			

Veterans were similar on measures of marital status, educational background, employment history, current income, criminal history, residential history, number of times homeless, tendency to violence, recent suicide attempts, VA outpatient visits during the past six months, and lifetime psychiatric hospitalizations. The one area in which veterans admitted to residential treatment in the two programs do differ is in their use of outpatient VA psychiatric or substance-abuse services during the six months prior to admission. In the HCMV veterans program, only 10 percent had three or more such visits, as compared to 44 percent in the DCHV program.

In addition to the many notable similarities between veterans admitted to residential treatment in the two programs, Table 5 also reveals much about the harshness of

their circumstances: 46 to 47 percent are divorced; 24 percent have been unemployed for most of the past three years; 54 to 56 percent had a total income of less than \$100 during the past month, and 1 to 4 percent had attempted suicide during the previous thirty days. In these characteristics, homeless veterans are seen to be quite similar to homeless persons described in other studies and surveys.²⁷

Thus, while veterans assessed overall in the two programs were quite different in their mode of first contact with the program, in their residential status, and in their hospitalization history, those who were admitted to residential treatment were far more similar. It appears that while the programs initially make contact with quite different segments of the homeless veteran population, a similar selection process occurs with respect to admission to residential treatment.

Relationship Between Veteran Characteristics and Admission to Residential Treatment

To obtain a clearer understanding of the admission process in the two programs, logistic regression analyses of the relationship of various veteran characteristics to admission to residential treatment in each program were performed. In this analysis, an adjusted odds ratios of the likelihood of admission is computed for veterans with specific characteristics as compared to veterans without those characteristics, with the influence of all other characteristics included in the analysis statistically controlled.²⁸ When the adjusted odds ratio for a particular characteristic is greater than 1.0, the likelihood of admission is increased for veterans with that characteristic. When the adjusted odds ratio for a particular characteristic is less than 1.0, the likelihood of admission is decreased for veterans with that characteristic.

The results of these logistic regression analyses for both the HCMI and DCHV programs are presented in Table 6. The strongest predictor of admission to residential treatment in both programs was current admission to a VA medical center or other institution, which increased the likelihood of admission to residential treatment in the HCMI program by 3.9 times and to the DCHV program by 1.4 times. In the HCMI program a history of past hospitalization (excluding those currently hospitalized) and the presence of psychiatric symptoms also increased the likelihood of admission. It thus appears that in both programs, currently institutionalized veterans and those with past experience of institutional treatment were most likely to be admitted, probably reflecting both their greater need for treatment and their greater tolerance of the constraints imposed by institutional care.

Several characteristics were associated with a *decreased* likelihood of admission in both programs: homelessness of less than one month's duration; current receipt of public support payments (from either VA or non-VA sources); current residence in an apartment, room, or house, and having been initially contacted through outreach. In the HCMI program, veterans who had been homeless for over one year were somewhat less likely to be admitted. These results suggest that both programs gave lower priority for admission to veterans who had some access to basic resources, namely, those who had been homeless briefly or had public financial support or housing. It is especially notable that those contacted through outreach were considerably less likely to be admitted than other veterans, most probably because they felt less need or were less tolerant of the constraints imposed by residential treatment.

While veterans assessed for these two programs differed substantially in their mode of first contact with the programs, in their current residential status, and in their past

and recent history of institutional care, they were generally similar in their current clinical, sociodemographic, and social adjustment characteristics. The admission selection process appears to have worked in similar ways in the two programs, with more institutionally oriented veterans, veterans who have been homeless for over a month, and veterans who lacked public financial support having a greater chance of admission than others. The special emphasis on outreach in the HCMI program clearly *did* allow the program to contact a segment of the homeless mentally ill veteran population that would not have been reached otherwise. However, those admitted to residential treatment in the two programs were similar to one another. It thus appears that while outreach programs may, in fact, reach underserved segments of the homeless population, segments not served by more conventional programs, those who are most readily engaged in treatment are quite similar to those who seek treatment on their own.

Table 6

**Logistic Regression Analysis of Veteran Characteristics
Associated with Admission to Residential
Treatment (HCMI) or Domiciliary Care (DCHV)**

I. Admission to Residential Treatment (HCMI)

	Odds Ratio	95% Confidence Interval
Currently Hospitalized in VA Medical Center	3.9	4.7-3.3
Past Hospitalization (Psychiatric, Alcohol, or Drug)	2.1	2.4-1.9
Psychiatric Symptoms	1.2	2.3-1.0
Homeless > 1 Year	0.9	1.0-0.8
Homeless < 1 Month	0.8	0.9-0.7
Contacted Through Outreach	0.7	0.8-0.6
Receives Any Public Support	0.7	0.7-0.6
Living in an Apartment, Room, or House	0.5	0.6-0.4

II. Admission to Domiciliary Care (DCHV)

	Odds Ratio	95% Confidence Interval
Currently Hospitalized in VA or Other Institution	1.4	1.6-1.2
Dual Diagnosis (Psychiatric and Substance Abuse)	0.8	0.9-0.7
Living in an Apartment, Room, or House	0.7	0.8-0.6
Homeless < 1 Month	0.7	0.8-0.6
Receives Any Public Support	0.7	0.8-0.6
Contacted Through Outreach	0.4	0.4-0.3

The Process and Outcome of Treatment

Although data on the important linkage, advocacy, and case management activities of the two programs will not be presented here, some preliminary information on the process and outcome of residential treatment can be reported.

Length of Stay

The principal measure of treatment process available for comparison in the programs is length of stay. Although substantial differences exist between the programs in average length of stay (75 days in HCMI versus 109 in DCHV), the two programs experi-

ence roughly similar termination rates during the first week of treatment (10% in HCMI versus 5% in DCHV) (Table 7). A somewhat greater rate of early dropouts is apparent during the first month of treatment in the HCMI program, perhaps because veterans are more often admitted directly from the community and are, therefore, less well prepared for the structured demands of residential treatment.

Differences between the programs are somewhat greater at the other end of the length of stay continuum, with 10 percent fewer veterans in the HCMI program staying for over 180 days (9% in HCMI versus 20% in DCHV). Both programs tend to have lengths of stay of about six months, but in the HCMI program a formal extension of the residential treatment contract is required after the first six months of treatment. Differences in length of stay between the two programs may also reflect the historical tradition of long lengths of stay in VA domiciliaries.

Table 7

**Length of Stay in Residential Treatment:
HCMI Veterans Program and DCHV Program***

	HCMI Veterans Program	DCHV Program	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV
0-7 Days	9.93%	4.54%	5.39%	-0.30% — 11.08%
8-30 Days	23.63%	16.80%	6.82%	1.55% — 12.10%
31-90 Days	33.51%	30.84%	2.67%	-2.20% — 7.53%
91-180 Days	23.77%	28.29%	-4.52%	-9.61% — 0.56%
> 180 Days	9.16%	19.52%	-10.36%	-15.84% — -4.88%
Total	100.00%	100.00%		

*Data in this table are based on all discharges (N = 2,091 [HCMI] and 2,307 [DCHV]), not just those for which an HVEB was completed at the time of admission.

Clinical Status at Discharge

Data on posttreatment outcome in these two programs are being gathered at a limited number of sites but have not yet been fully analyzed. However, preliminary information on the outcome of residential treatment is available, from the discharge summaries, in three outcome domains: program status at the time of discharge, residential status, and employment status.

Program status at discharge. There was no significant difference in the percentage of veterans in each program who successfully completed residential treatment (34.4% in HCMI versus 35.2% in DCHV), although there were some differences in the rates of specific types of unfavorable discharges. A significantly greater percentage of veterans admitted in the DCHV program dropped out or were discharged for a rule infraction, while slightly more veterans in the HCMI program were too ill to continue in residential treatment and were transferred to another program for further institutional care (Table 8). The modest proportion of those admitted who successfully completed residential treatment in these programs reflects the significant difficulties encountered in engaging the homeless mentally ill in treatment. Other programs that treat impoverished substance-abusing patients have reported similarly low rates of program completion.²⁹

Residential status. About one third of those discharged from residential treatment in each program were known to be moving to an apartment, room, or house at the time of discharge. Veterans discharged from residential treatment in the HCMI pro-

gram were significantly living in such settings less often than those discharged from the DCHV program, and they were more apt to be living in another institutional setting (Table 8). These differences, however, most likely reflect the greater duration of homelessness among HCMI veterans and their lower prior use of institutional treatment. DCHV veterans were more likely to have completed an episode of hospital treatment prior to admission to the DCHV program, and as a result, they may have been more ready for community reentry than veterans in the HCMI program.

Table 8

Clinical Status at Discharge from Residential Treatment from the HCMI Veterans Program and the DCHV Program

	HCMI Veterans Program N = 1,453	DCHV Program N = 1,870	HCMI- DCHV Difference	95% Confidence Interval of HCMI-DCHV Difference
A. Discharge Status				
Successful completion	34.4%	35.2%	-0.8%	-4.0% — 2.5%
"Kicked out"	19.8%	25.1%	-5.3%	-8.2% — -2.5%
Dropped out	27.2%	30.7%	-3.5%	-6.6% — -0.4%
Transferred	8.5%	4.8%	3.8%	2.0% — 5.5%
Other	10.1%	4.3%	5.8%	4.0% — 7.6%
Total	100.0%	100.0%		
B. Residential Status				
Apartment, room, house	32.5%	45.1%	-12.5%	-15.8% — -9.2%
Institution	26.9%	19.0%	7.8%	4.9% — 10.7%
None/unknown	34.0%	33.5%	0.5%	-2.7% — 3.7%
Other	6.6%	2.4%	4.2%	2.7% — 5.7%
Total	100.0%	100.0%		
C. Employment Status				
Full time	24.2%	28.3%	-4.1%	-7.1% — -1.1%
Part time	13.4%	8.7%	4.7%	2.5% — 6.9%
Vocational training	4.9%	7.4%	-2.5%	-4.1% — -0.9%
Unemployed	35.9%	39.2%	-3.3%	-6.7% — 0.0%
Retired/disabled	16.7%	14.1%	2.5%	0.1% — 5.0%
Other	5.0%	2.2%	2.7%	1.4% — 4.0%
Total	100.0%	100.0%		

Employment status. Differences in overall employment status at discharge were also minimal, with almost 40 percent employed in both programs. The proportion of veterans in the HCMI program who were working in full-time jobs at the time of discharge was less than in the DCHV program (24% versus 28%), but the proportion who were working at part-time jobs was greater (13% versus 9%).

In responding to the crisis of homelessness as it has emerged during the past decade, the Department of Veterans Affairs developed two national health care programs with somewhat different clinical emphases to help homeless veterans suffering from medical, psychiatric, and substance-abuse problems. Data available from the evaluation of these two programs are among the most extensive available from any health care program for the homeless mentally ill, and thus provide a unique opportunity to consider the place of specialized health care programs in the national response to the crisis of homelessness.

Veterans Evaluated

Veterans evaluated by the two programs, as well as those who were admitted to residential treatment, were quite similar in their sociodemographic characteristics and in the prevalence of current clinical and social adjustment problems. Homeless veterans are not markedly different from other homeless males in the severity of their health care problems and in their abysmal social circumstances. One way in which they do differ, of course, is in their military and, more specifically, combat experience.

In several previous studies, we have examined the combat experience and combat-related psychological problems of homeless veterans.³⁰ While combat veterans do tend to have somewhat more severe psychological problems than other homeless veterans, it is the nightmare of their homelessness, rather than their war-related symptomatology that appears to be most in need of immediate clinical attention,

New Initiatives

As a result of the evaluation results reported here, a number of new initiatives have been launched by VA, each of which seeks to link innovative mental health services with additional types of assistance. These initiatives have been inspired by a desire to expand the range of help provided, and by the wish to link VA health care services more directly with other types of largely non-health-related assistance.

The first effort is an internal VA program, the Compensated Work Therapy/Therapeutic Residences Program, a long-term effort to provide vocational rehabilitation and transitional housing to homeless substance abusers. In this initiative, VA purchased community residences in which homeless veterans who have completed a substance-abuse treatment program can live and work in a "dry" supportive community for up to eighteen months. Particular emphasis is placed on the interrelationship of sobriety maintenance and work. Patients are required to participate in a supported community employment program, VA's well-established Compensated Work Therapy Program, and to contribute, out of their earnings, to the upkeep and maintenance of the residence.

The second effort involves a collaborative outreach effort undertaken in conjunction with the Social Security Administration (SSA) for those homeless veterans who are medically or psychiatrically disabled and cannot return to work, at least in the short run. Through this collaboration, claims representatives and disability determination specialists funded by SSA have begun to work, on site, with VA clinicians to provide stronger links between VA clinical services and the financial assistance available through the Supplemental Security Income (SSI) and Social Security Disability Income (SSDI) programs. In this initiative, therefore, VA clinicians team up with SSA personnel to broaden the range and responsiveness of services they can provide and to improve ease of access to financial support for those who cannot work.

A third initiative, a collaboration between VA and the Department of Housing and Urban Development (HUD), was slated to begin at nineteen HCMI and DCHV sites in the spring of 1992. For this program, the HUD-VA Supported Housing program (HUD-VASH), HUD has agreed to set aside 750 Section 8 housing vouchers for use by veterans. VA case managers have been deployed to work intensively, over many years, with the homeless mentally ill veterans admitted to this program. It is

believed that the availability of Section 8 vouchers will greatly facilitate the housing procurement process for these veterans, and that the combination of accessible and flexible housing subsidies and sustained case management will result in greatly improved clinical outcomes.

In each of these efforts, and in others that cannot be fully described here, VA has sought to link its clinical initiatives with other types of service, often nonmedical in nature, to offer a comprehensive range of integrated assistance. The data presented here suggest that the homeless mentally ill require far more than health care services and that health care programs seeking to assist them must vigorously link their efforts with those of other agencies and resource pools.

On any given night, there may be as many as 200,000 homeless veterans in America. If every one of the 70,000 beds in the entire VA health care system was used to provide shelter and care for these veterans, just over one third of those needing assistance could be helped. Although these statistics are rough estimates, they clearly demonstrate the immensity of the homeless problem in America.

The homeless are, perhaps, as diverse as any other group of Americans. They come from small towns and big cities, from all racial and ethnic groups, and they face a variety of social adjustment and health care problems. No single program could meet the various needs of this entire population, nor could any single program meet the needs of even one small subgroup. Multiple and diverse approaches are needed and, as we have shown, large agencies like VA are developing a broad spectrum of humane, caring programs that successfully make contact with a variety of segments of the homeless population. It must be acknowledged, however, that the results of even innovative health care programs like those reported here are modest at best, and woefully inadequate to address the full measure of the tragedy of homelessness in America. Nevertheless, these programs must not be abandoned or devalued because they cannot address all the needs of all the homeless mentally ill or because their clinical success is partial. Rather, they must be regarded as crucial pilot efforts through which the health care community is gaining experience in providing assistance to the homeless and through which we are learning new ways that health care programs can be broadened and expanded to better meet the needs of the homeless mentally ill.

Neither health care programs nor any other single type of service program can end the tragedy of homelessness in America. Homelessness is only the tip of a much larger constellation of interrelated social problems that include the deterioration of American cities, the shift away from an industrial economy, the regressive redistribution of wealth,³¹ and massive minority unemployment.³² A major reorientation of national priorities will be needed before these profound social problems, including homelessness, can be addressed on the scale required. In the overall scheme of things, current health care efforts on behalf of the homeless must be regarded as partial, exploratory, and even experimental. They will not in themselves put an end to homelessness among the mentally ill. But the clinical successes of these programs, as well as the professional experience and expertise gained through them, must not be dismissed because they do not represent a full solution to an imposing problem. Current gains in knowledge and experience will be of vital importance if and when the nation commits itself, on the massive scale required, to addressing the problems of the homeless mentally ill and the larger problems of what we must, once again, regard as the "other America." 🐼

After four years of operation, the HCMI and DCHV programs have become well-established entities within VA's overall health care effort. Paul Errera, M.D., and Richard Olson, M.H.A., deserve primary credit for the progress of their programs, and we want to thank them for their support of our evaluation efforts. Gay Koerber, M.A., of the Mental Health and Behavioral Sciences Service has been a beacon of orientation for VA's homeless programs nationally. At NEPEC, Sharon Medak, Dennis Thompson, Alex Ackles, Bernice Zigler, Linda Corwel, and Pamela Gott have contributed to the success of our evaluations through their meticulous attention to detail. Virginia Emond, Karen Arena, and Vera Ratliff, who form NEPEC's nerve center, have played a vital role in integrating the national information network that makes program evaluation possible. Above all, we want to thank the program directors, staff clinicians, and evaluation assistants at the seventy-one HCMI and DCHV sites, whose courage and caring have made these programs happen. To all, we extend our thanks.

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Streets Are for Nobody: Awilda Cruz

Thirty; one of ten siblings; abused at an early age; kicked out by mother; pregnant at twelve. Successfully completed substance-abuse treatment; has apartment, job, her daughter back in her life, supportive relationship. Began GED classes January 1991 and plans to attend college.

I have been just so disconnected from my past since I've been a child. God knows who's what, when, and where.

For a lot of Hispanic background, their culture is you deal with your problems in your house and you don't tell nobody and if you do, "*Shh!*" you know, how dare you! You get slapped — you know, get punished. So how were you gonna come out with these issues?

[Her daughter was taken away. She began drinking at fourteen, found a job and an apartment, and got her daughter back.]

I just went like first year of high school and had to drop out because having to work a job and having my daughter at the same time — I went on temporarily, um, AFDC until I started workin'. And that worked out for a while. But, um, I met the man which I thought was the man of my life and my dreams and was gonna rescue me and take me away from this impossible world and he was someone that drugged and dranked just like me. We went out for two years, the result of it — I had a son from him. There was a lot of mental abuse, a lotta physical abuse, and, um, I decided I took enough of that in my first marriage and now it wasn't gonna happen in my second life around, you know. So, I left him.

So from fifteen to eighteen, I was in Hartford, Connecticut, and decided to settle down. It was just a geographical cure. I stopped drinkin' and druggin' for about two years. This time I was gonna try it differently, a religion way, and have this higher power in my life, a spiritual foundation. My husband started to come back in my life. I wanted him back in my life because I had a son with him, and I didn't want to end up like my mother, an alcoholic without knowing who the fathers of her kids were — she was never married — I just didn't want to be like her. I wanted to have a real chance in life.

I lived about eight years in Hartford, Connecticut, and I tried to build a . . . foundation out there, but, I found myself in a real bad financial setting, real bad, and decided to make fast cash. I decided — I'll have a legal job and a illegal job and sell drugs and make fast money, so I'll be able to survive.

Interviewed by Melissa Shook, July 29, 1989, Shepherd House, Dorchester. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

Last year I got arrested for trafficking heroin and, um, I believe then I hit my bottom. By going up to Framingham [prison] and seeing myself in the situation I was in, I had no other choices but to know that Awilda had a problem with alcohol and drugs. It didn't convince me that first time around because, as soon as I came out, I did the same thing over and over. But the second time, I, um, I feel like I surrender because I wasn't that lady that was always dressing up real high class or had my Eldorado and have my nice home in Providence, Rhode Island. All these things were taken away.

The last time I shove a needle up my arm, I was sayin', "Oh, God, help me. This hurts and I can't do it no more. I'm gonna die. I'm . . . I'm desperate. Help me." And I kept on cryin' and I took the needle outta my arm. I said, "The hell with this. I can't go through this insanity no more." And that's when I went for help. 20

From Lemons to Lemonade

An Ethnographic Sketch of Late Twentieth-century Panhandling

Louisa R. Stark

A rise in the number of panhandlers on the streets of this country has given rise to the promulgation of ordinances outlawing this activity. Although there has been a great deal of press and litigation revolving around such public policy, little is known about homeless panhandlers. This article reviews the rather limited information about what is known of the sociodemographics of panhandling. Strategies used by panhandlers in pursuing their occupation are described, along with their own perceptions of their occupation. Services available to this population are discussed, along with some suggestions for resolving the problems associated with panhandling on America's streets.

The 1980s may be characterized as the decade of the homeless. Numerous catastrophic events, including massive deindustrialization, salaries and welfare benefits at a level too low to maintain even the most rudimentary livelihood, and a series of recessionary cycles have caused thousands of Americans to lose their economic underpinnings and become homeless. As numbers grow, public and private service providers have been able to impact the need for services for homeless people only minimally. This has led to an increase of homeless and poor people who have begun turning in increasing numbers to begging.

As the numbers of mendicants have grown, complaints about begging have led to the development of public policy to deal with the problem. In 1987, Seattle passed a law making "aggressive panhandling" punishable by ninety days in jail or a \$500 fine. In 1988, Minneapolis passed a similar ordinance, as did Atlanta and Dallas in 1991. Miami promulgated an ordinance against begging in general in 1988, while New York City enacted a law specifically against panhandling in subways in 1989.¹ Although these laws have been put forth in an attempt to regulate public behavior that discomfits the citizenry, they appear to have been passed with little knowledge or understanding of who panhandlers are and why begging is on the rise in urban America.

This article attempts to broaden our understanding of contemporary mendicancy, beginning with a discussion of the public's perceptions of panhandlers, followed by

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an examination of some of the demographic and social characteristics of this subgroup of homeless people. The next focus is on the entrepreneurial strategies of panhandlers along with their own perceptions regarding their occupation, including, whenever possible, the voices of informants. The relationship between mendicants and available welfare and homeless services is reviewed. I conclude with a few suggestions for resolving the problem of panhandling on America's streets.

Research for this study has been conducted over the past ten years, and is based on participant observation carried on in connection with my administration of several housing programs and research projects dealing with homelessness. Although the study was carried out in Phoenix, I hope that its conclusions may be applicable to other urban areas.

This article focuses on the kind of mendicancy known as panhandling. The contemporary definition of panhandling combines the notion of begging with a story of need, which is generally perceived as not matching the manner in which money given will be spent. The term "panhandling" also embodies an element of assertion. Panhandlers are seen as proactively asking for money, not simply standing or sitting and waiting for it to come their way.²

The public perception is that there are large and persistently growing numbers of panhandlers. This may be partly due to the fact that panhandlers are often the only direct contact an average citizen has with a homeless person. When such an interaction occurs, with an often disheveled stranger invading the personal space of an unsuspecting citizen, the individual approached may believe that (1) the situation is a dangerous one, and (2) that all homeless people are panhandlers. Part of the perception of danger may be related to the fact that today, as distinct from earlier times, many panhandlers are young men who are perceived as being stronger, and thus more potentially dangerous, than the stereotypical older mendicant of the past. The intensity of feeling about the contact may make the problem seem larger than it actually is. In fact, the actual percentage of homeless people who panhandle is low, although growing. A study of homelessness in Minneapolis-St. Paul has shown that the total number of homeless people who reported that they panhandled increased from 8.8 percent in 1989 to 12 percent in 1990.³ Studies of homelessness between 1985 and 1989⁴ reveal the data on panhandling shown in Table 1.

Unlike the old Anglo man who was the stereotypical panhandler of the past, the modern street beggar is generally representative in age and ethnicity of the general homeless population; he or she is generally young⁵ and a member of a minority group.⁶ For example, in a comparison of two shelters in New York, only 4.1 percent of men over the age of forty-five indicated that any of their income came from panhandling, whereas 14.2 percent of the men staying in a shelter that catered to younger clients reported income from asking strangers for money.⁷ In Phoenix, the majority of panhandlers are young African-American or Native American men. However, like the mendicant of the past, the modern panhandler is generally addicted to alcohol and/or drugs.

The modern panhandler often considers begging a job,⁸ in many ways an entrepreneurial enterprise. He is out to make money in the most efficient manner possible. This includes setting up shop in an optimal business location, selecting clients who will be receptive to his sales message, and developing a sales pitch that will convince a potential client that his product (himself) is worth an investment at a reasonable price.

Table 1

City	Percentage
Washington, D.C. ^a	34.4%
Chicago ^b	24%
New York ^c	14.2%
Los Angeles ^d	13.4%
Milwaukee ^e	13%
Denver ^f	6.8%
Nationwide ^g	17%

Source Notes

- a. Kathleen H. Dockett, *Street Homeless People in the District of Columbia: Characteristics and Service Needs* (Washington, D.C.: University of the District of Columbia, 1989), 36. Homeless individuals living on the streets were interviewed at meal sites. When asked the question, "In the past thirty days where did you receive money from?" 34.4 percent mentioned panhandling.
- b. Peter H. Rossi, Gene A. Fisher, and Georgianna Willis, *The Condition of the Homeless of Chicago* (Amherst, Mass.: Social and Demographic Research Institute, University of Chicago, September 1986), 88. In 1985 and 1986, surveys were conducted of 722 homeless people staying in shelters and on the streets, of whom 24 percent reported that they engaged in panhandling.
- c. Merv Goldstein, Stephen Levine, and Robert Lipkins, *Characteristics of Shelter Users* (New York: Adult Services Agency, Bureau of Management Information Systems, Human Resources Administration, City of New York, April 8, 1986), 17. In this study 14.2 percent of men staying at a shelter "designated to receive clients brought in by outreach efforts" stated that a current source of income was panhandling.
- d. Roger K. Farr, Paul Koegel, and Audrey Burnam, *A Study of Mental Illness in the Skid Row Area of Los Angeles* (Los Angeles: Department of Mental Health, March 1986), 205. Respondents were 300 homeless individuals who availed themselves of beds in missions, hotel rooms (through vouchers), or shelters, who used free meal services and indoor day programs, or who were hanging around on the streets. When asked about their sources of income, 13.4 percent responded that they received money from panhandling.
- e. Mark Rosnow, Toni Shaw, and Clare Stapleton Concord, *Listening to the Homeless: A Study of Homeless Mentally Ill Persons in Milwaukee* (Milwaukee, Wis.: Human Services Triangle, April 1985), 17. In 1984 and 1985, interviews were conducted with 237 homeless individuals living in temporary shelters or on the streets. Of the total, 13 percent admitted that they earned money occasionally by "asking for change."
- f. John Parvensky and Don Krasniewski, *In Search of a Place to Call Home: A Profile of Homelessness in Colorado* (Denver: Colorado Coalition for the Homeless, October 1988), 22. A total of 814 homeless individuals were interviewed in soup lines, shelters, on the streets, and at emergency service centers. When asked their primary source of income during the prior month, 6.8 percent stated that it was "money from strangers."
- g. Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs That Serve Them*, Urban Institute Report 89-3 (Washington, D.C.: Urban Institute, July 1989), 43. Data were collected from 1,704 "homeless adult users of soup kitchens and shelters in cities of 100,000 population or larger (36) who were asked to list their current sources of income. Seventeen percent listed "handouts" as a source.

Business Locations

Locations for panhandling generally fall into two general categories: sites that are close to a source of liquor (or drugs) where the panhandler will spend his or her hard-earned cash, and locations where the potential donor will have cash already in his or her hand, thus making it difficult to make up an excuse of having no spare change.

Panhandlers who prefer to work the streets in proximity to liquor stores or bars may often be found in the downtown commercial areas of larger cities. Such locales usually boast a few pre-urban renewal bars still frequented by homeless and poor skid row men. Downtown commercial areas are also preferred by certain panhandlers because, as Calvin, a forty-two-year-old panhandler in Phoenix, explains, "You can blend in. There are always a lot of people on the street. You can also simply move away with the crowd when you see the cops coming along."

The same informant, referring to the positive aspect of crowded downtown streets, adds, "It's not like being on an empty street, and approaching some guy who's scared shitless when he sees you coming towards him. You scare them too much and they run for cover, or worse yet, for a cop."

Panhandlers also work people in cars. This generally occurs at intersections in front of a liquor store. In this style of panhandling, there is no pretense on the part of the panhandler — the money will be used for alcohol. For the person being hit up, the experience is one of mixed reactions. While the car serves as a physical barrier between driver and panhandler, the fact that the vehicle is usually forced to be in a stationary position by a traffic light may lead to a good deal of discomfort on the part of the driver, who may feel trapped and at the mercy of the panhandler.

As in many other cities, panhandling ordinances in Phoenix are most often enforced in the downtown commercial area. Thus, a number of panhandlers prefer to locate their operations elsewhere, fanning out into nearby neighborhoods where alcohol can be purchased in supermarkets and drugstores, along with food, aspirin, and diapers. Such locations are becoming more frequent sites of panhandling. However, unlike a direct request for money with which to purchase alcohol made in proximity to a bar or liquor store, truth in advertising becomes somewhat shaky when the plea is delivered in front of a supermarket or drugstore. There the money is said to be for food or medication or, in the case of women, to purchase diapers. Rita, a homeless alcoholic explains.

It's much easier for me to make a few [dollars] standing in front of Safeway [a local supermarket] for food and diapers for my kids. People are going to give to me because they think I'm going to go right into the store and spend the money that I collected. I can get money much faster than I can downtown. Down there, nobody is going to believe that I'm going to take their money, hop a bus, and go buy the stuff. But if you're standing right in front of a place where they sell the things you're asking for, then folks are more apt to believe your story.

Rita has no children!

Alcohol is sold in convenience stores, which also sell gasoline. It is therefore not uncommon to find panhandlers standing near gas pumps asking for money because "I ran out of gas" or "I just got a job, but I don't have enough money for gas to get there" or "My car broke down on the freeway, and I need to get it towed." In Phoenix, some panhandlers have become so ingenious that they tote old dented gas cans to "prove" their need.

Panhandlers are often found around locations where a "hit" will have cash in hand, so that it is difficult to deny having spare change. Many Phoenix panhandlers have concluded that panhandling is best carried out where citizens are already engaged in a financial transaction. They believe that a second transaction, making a "donation" to a panhandler, can be more easily induced once a purse or billfold has been opened for another purpose. Locales such as parking meters, phone booths, and automatic teller machines are often frequented. As Ed, a young high school dropout in his early twenties states,

You might call my beat the parking lots around City Hall. I go up to people who are just about to feed a parking meter. They already have some change in their hand, so they can't [say] that they don't have any money. Usually I get just a couple of coins. But I'd say almost everyone I approach gives me something.

A close second to the money-in-hand technique is the money-just-spent or money- about-to-be-spent strategy. This is often associated with locations like restaurants and food stores. As Leon, a forty-three-year-old longtime street person and alcoholic relates,

I usually stand near the Matador [a downtown restaurant]. You can hit up people going into the restaurant for a meal, or just when they're leaving. They've just paid for a good meal, or are just about to, and they see me looking hungry and, well, before I know it I have the change I need.

Customer Profiles

Besides a good choice of location, a successful panhandler usually has an idea of who will be his most successful "hits." For example, the downtown area of many large cities is viewed as a place to interact with conventioners and tourists, who are often seen as easy marks. As Joe, a twenty-seven-year-old Phoenix panhandler, explains, "Tourists are great. They're on vacation, feeling good about themselves. They're spending a lot of money anyway, so what's a little more thrown in."

Other beliefs associated with potential generosity include the assumption that a man accompanied by a woman will respond to being hit up more readily than two men together or one man alone. As Mark, a veteran panhandler, remarks,

Couples are almost always sure marks, especially if it looks like they're out for a big night. The guy, who's going to spend a lot of money to impress his girl, doesn't want to take any chances that she might be put off if he's doesn't help a poor guy like me. He's also probably feeling somehow guilty that he's going to be spending all that money on one night with his woman, when there's a poor person like me asking him for a little thirty-three cents to help me get on a bus.

In general, most male and female panhandlers agree that women are not easily approachable. Les, a "pro," explains: "It's hard to get anything out of a woman. It seems they think that if they open up their purse to give you something that you're going to grab it and take off."

Marketing Strategies

Besides the importance of location and type of potential "hit" one approaches, the nature of the request plays an important role in the equation. As noted, there is often a nexus between the site of the panhandling and the kind of appeal made, namely Ed, who panhandles around the parking meters at City Hall, asks for change to buy gas for his car; Rita, who operates in front of a supermarket, requests money for diapers; and Joe, who works the streets near the bus depot, always asks for bus fare. The object of the request, however, rarely matches the expenditure of the donation, which more often than not is used to pay for alcohol or drugs. The exceptions are the few panhandlers who honestly request money to buy a drink — but never drugs! Eva is an example. Standing in front of a liquor store, she often asks passersby for "fifty cents to start a quart." Eva relates that her hits often give her a dollar, and tell her to go buy herself a whole quart. Such are the rewards of honesty!

Finally, like sales personnel everywhere, many panhandlers conclude a business transaction with "Have a nice day!" even when their solicitation has been turned

down. In fact, as Al, a thirty-two-year-old homeless man reports, "I don't know why, but sometimes I really get a kick out of telling someone to have a nice day after they've turned me down. I know they're squirming inside — feeling guilty that they didn't want to help me out."

Pricing

Although a well-known Phoenix panhandler generally asks a hit for a million dollars, there is usually a relationship between the amount of money requested and the object for which it will purportedly be spent. For example, a panhandler may ask for eighty cents for bus fare or a dollar for a gallon of gas. In some cases, Phoenix panhandlers simply ask for an unspecified amount of money to purchase gas, food, diapers, and so forth. The exact amount is not mentioned; it is left to the hit to decide the amount necessary to purchase such articles. Finally, some panhandlers ask for a specific sum of money necessary to complete the total necessary for a purchase. Harry, a veteran panhandler, always asks for thirty cents.

I always show them a couple of quarters, and tell them that I only need thirty cents more for bus fare [eighty cents]. Of course, you know me well enough to know that eighty cents is what a pint of "T-Bird" [Thunderbird, a brand of fortified wine] costs. But the average Joe walking down the streets is real impressed that I've gotten most of the money I need, and is probably more apt to give me what I ask for.

As a staff member of a social service agency once noted: "It's almost as if [panhandlers] are aware of the concept of 'matching funds.' I suppose if it works in grant writing, the same psychology should work on the streets."

Profits

Income from panhandling is generally limited. In a 1986 study of homelessness in Chicago, the average income reported from panhandling was \$7.00 per month.⁹ This may be partially explained by the fact that panhandling is generally not a daily occurrence. For example, in a 1986 study carried out in Los Angeles, of the 13.4 percent of homeless people interviewed who admitted to panhandling, only one percent stated that panhandling constituted their whole income, 2.2 percent mentioned that it made up most of their income, and 10.2 percent stated that it comprised only part of their income.¹⁰ Panhandling is generally engaged in when other economic resources, such as earnings, money from family or friends, sale of plasma, or "dumpster diving" — scavenging for recyclable goods — have been exhausted.

Earnings are rarely saved. They are spent on short-term purchases, generally alcohol or drugs, occasionally food. Since the amount earned is minuscule, there is no reason to try to save it for housing, even in an SRO hotel. As Melvin, a thirty-two-year-old alcoholic reports, "There's no way that I could save any of the money that I get on the streets. Even if I could get in, the Golden West [a local SRO hotel] would charge me \$8.00 a night. I'm lucky if I make \$2.00 a day."

Beyond this, saving the money and carrying it around can only lead to being robbed, and possibly being beaten up in the process. This being the case, the average Phoenix panhandler works the streets only until he or she has enough money to

purchase a bottle of beer or fortified wine, a vial of crack, or, rarely, a meal at a fast-food restaurant.

The alcoholic drinks the beer or wine with the intention of getting as intoxicated as possible. At that point, barely able to walk, or having passed out, the panhandler obviously has to postpone further panhandling to another day, or until the person returns to some semblance of sobriety.

Many long-term alcoholics find that they do not need to consume large quantities of alcohol to become intoxicated. A couple of swallows of fortified wine often suffice. Since the alcoholic does not require a whole bottle, the remains of which would be stolen once he became intoxicated, he often joins an impromptu "bottle gang" of like individuals with whom he combines his earnings to purchase alcohol. The group meets, usually in front of a liquor store, and decides to raise the necessary funds. They may decide to divide the cost of the alcohol evenly, each individual panhandling to collect his quota. Or each member panhandles for a specific length of time, perhaps an hour, returning with whatever he has been able to raise. Once this arrangement is made, it is a point of honor that each person adds every penny collected to the pot. The quality and quantity of liquor bought is determined by the amount of money collected. Those who join a bottle gang make their earnings go further and are thus able to spend less time panhandling. Sharing the cost of the bottle, as well as the bottle itself, ensures each member enough alcohol to become intoxicated, while avoiding waste of money or liquor. Charles, a recovering alcoholic and former panhandler recalls:

When I was on the street, I found that two or three swigs and I'd be gone — passed out. So if you bought a whole jug [bottle of fortified wine] you'd just sip a little, pass out, and then it would be gone. Somebody would walk off with the rest. Then you'd come to in an hour or so and need some more. And you'd have to figure out how to get another jug. So it was much better to share, with everyone taking a few swigs. That's a much better way to do it. That way you weren't paying a lot for what you didn't drink.

Homeless mendicants either embrace or distance themselves from their role as panhandlers.¹¹ Kevin, a nineteen-year-old drug user, is one who distances himself from panhandling. He tells a listener that he never panhandles. In fact, his source of income, he says, comes from an inheritance left him by his uncle. Yet further queries reveal that Kevin was kicked out of high school at the age of sixteen for drug abuse, his family disowned him, and he has been in and out of the correctional system ever since. Only recently has he begun supporting himself selling plasma and panhandling. When Kevin finally admits that he secures most of his income from panhandling, he adds, "You know, I gotta be stoned to do it. There's no way I can go up to someone and ask them for money straight. It's really demeaning. It just goes against my grain."

Homeless people who distance themselves from their roles as panhandlers have generally spent less time on the streets than those who embrace the identity.¹² Marvin, a thirty-six-year-old alcoholic, embraces the role. He had been homeless for two years before he decided to "clean up." When interviewed, he had spent three of the previous six months in a detox program. After that, he had been employed as a property manager until he started drinking again and lost his job. Homeless once more, he started supporting himself by panhandling. He called his former employer

to report, "God, it's great to be out [on the streets] again. It's always an adventure. They call me Ghost Walker [Marvin is Native American], but I call myself Joe Walker, because I come and go."

Not surprisingly, those who embrace panhandling share the belief that there is nothing dishonorable about this activity. When criticized, many panhandlers testify that they see no difference between asking for money for their own needs, and the practice of charitable organizations that request funds, often on the streets, to help the poor. Julie, an articulate young woman who was arrested for panhandling in front of a drugstore, was furious when a case manager at a social service agency confronted her over the incident.

Who the hell do you think you are, criticizing me for panhandling. I see you doing the same thing, yourself. Almost every night I see you on TV, begging for money from the public to help the homeless. And I hear that woman at CASS [a local emergency shelter] telling people that they should give to the shelter instead of to us directly. And you guys are always saying that we need to be "empowered," but you don't want us to be allowed to raise money for ourselves — for our own needs as we determine them. You know, it's all a bunch of crock.

Ed, a veteran panhandler, holds much the same opinion.

I hear all this business about how we poor stiffs go around asking for money for food and stuff like that when all we're really interested in is spending it on alcohol. I think that's called truth in advertising. But I also see those charity people begging for money, saying that it's all going to go directly to helping homeless families. You know that's not the truth. Only a very little goes directly to anyone. They use most of it to pay themselves big salaries. It's all a big racket.

Similarities between panhandling by homeless people and solicitation by charitable organizations have also been noted by the National Coalition for the Homeless. In an article discussing the repeal of Cincinnati's panhandling ordinance, the coalition states: "This controversy raises the question why people think it is okay for the Salvation Army 'Santa Claus' to ask for donations which will help homeless people, but why it is not okay for homeless persons to ask for donations to help themselves directly."¹³ And in their attempt to overturn the New York City ordinance outlawing panhandling in the subways, attorneys for the two homeless plaintiffs argue that their clients "are entitled to the same constitutional protections as charitable solicitors under a string of Supreme Court rulings that sharply limit the right of government authorities to regulate fund-raising efforts."¹⁴

Part of the reason for the negative attitude that panhandlers often have of charitable organizations may come about because they generally do not, or cannot, avail themselves of their services. Many of the nation's homeless programs, including emergency shelters, do not serve homeless people who have been drinking heavily or who are under the influence of drugs.¹⁵ Since there are never enough beds available for those who need them, shelter administrators can pick and choose those they assist, so substance abusers are often not served. As the administrator of a Phoenix shelter explains:

We have made some priorities. First we help the most vulnerable homeless — families with children and the elderly and disabled. Our next priority are single workingmen and -women. We don't have a policy of not helping substance

abusers. But when they come in under the influence, they can be very unruly. My staff also feels that they've made a choice. They could have spent their money on a place to stay, but instead they use it to buy alcohol or drugs. My employees don't feel very kindly towards alcohol and drug users. If there were a distinction between deserving and undeserving homeless people, I'm afraid they'd classify the substance abuser as undeserving.

Bill, a thirty-six-year-old panhandler who is also an alcohol and drug abuser, reports on his experience with a shelter for the homeless:

Yeah, I was eighty-sixed [evicted] from CASS. I came in drunk and stoned out of my mind one night, and one of the intake guys took one look at me and kicked my ass out. I mean, I've been permanently eighty-sixed from there. But, shit, the place is really a dump. They're always telling you what you can do, and what you can't. They're worse than the army, and I should know what I'm talking about. After spending four years in 'Nam, I don't need to put up with that kind of shit. I don't need a shelter to be able to take care of myself.

Because of shelter policies, many homeless alcoholics find themselves relegated to a life on the streets, without access to social services. As a result, homeless substance abusers are often denied the one service from which they could most benefit, detoxification. In Phoenix, access to a public detox program necessitates a referral from a social service agency. However, even for a shelter resident who may receive a referral, there is often a six- to eight-week wait for a bed in the program. Many homeless substance abusers simply cannot wait that long and, unable to control their addiction, find themselves evicted from their emergency housing and back on the streets. As "Rambo," a thirty-eight-year-old alcoholic reports:

About a year ago I decided that I wanted to clean up my act. I actually sobered up long enough to get into CASS so I could get a referral to the LARC [local county alcohol recovery center]. When my case manager called, they told her that it would be a six-week wait. I tried real hard to remain sober, but couldn't hack it after two weeks. One day, after getting off work [casual labor], I was walking back to the shelter with a couple of other guys who'd just gotten paid. One of them had a bottle, and we started drinking. That was the night I was eighty-sixed from the shelter, for being late and loaded. So the detox program went down the tubes. I guess I'll never get straight. It's just too hard to do in this town.

Homeless people, once back on the streets, attempt to face life with a certain amount of bravado. They often talk about how sleeping on the streets is preferable to staying at a shelter and, in the case of panhandling, the positive challenge of this form of economic activity. However, one should not be tricked into thinking that the life of a street person is all freedom and pleasure. The fact is that few homeless people have much if any freedom, if freedom is defined as choice. The average homeless person is offered very few alternatives that are more rewarding than life on the streets.¹⁶

To a homeless person the choice of the street over a shelter, for example, may either be no choice at all (if he or she has been evicted because of an infraction of rules), or may have been a limited choice if the shelter was deemed to be less safe than the streets. Yet whatever the limited choice, it is pursued positively. Snow and Anderson point out "the tendency for individuals who have fallen through cracks of society to carve out a modicum of meaning and personal significance."¹⁷

In many ways panhandlers, whose activities are severely stigmatized by the rest of society, have developed techniques and strategies that have enabled them to endow their economic undertakings with a positive meaning and significance. However, it is also true that such individuals, in more sanguine moments, can be quite objective about themselves and their situation. Linda, a twenty-eight-year-old alcoholic, talks about her life:

I got married when I was sixteen. We lived with his parents, and had two kids. My husband and I were drinking so much that finally my in-laws kicked us out. So we left for Phoenix, 'cause my husband thought he could get a job. And we wouldn't be bothering anybody with the way we lived. Robert found a job welding, and I got pregnant again. But when the baby was born, the state took him away from us. [The baby was born with fetal alcohol syndrome.] Robert blamed me for the baby's problems, and one night he came home and beat the shit out of me. I called the police and they threw him in jail. Without him I couldn't keep the apartment, so I'm on the streets.

Everybody loves me here. Maybe it's 'cause I'm so good at getting money. All I gotta do is smile and hold out my hand, and I have enough for a jug. Am I happy? Well, sure. Everybody loves me, and I can get as drunk as I want to. And nobody can tell me what to do — not my husband, not his parents — nobody. But you know, sometimes early in the morning I think about the res [reservation], and my children. And I think about how I don't know them, and how they don't know me. And I get very sad. And sometimes I think that I want to go back, and clean up, and not be totally screwed up. But I can't. It's too far away. There's no way to get there from here. So I just smile, and beg, and drink. And smile, and beg, and drink. I guess that's all I can do, wouldn't you say?

Don, alias "Red," who has been homeless for twelve of his thirty-two years, describes his situation:

You know, I'm pretty well known around here. Everybody knows Red. They also know I'm the best. I can beat anyone in getting the change I need to keep me going. But when someone like you keeps asking me why I do this, and just keeps asking and asking — well, it finally got me to thinking. I do it 'cause there's nothing else I can do. Now who's going to hire a thirty-two-year-old alcoholic?

I used to try and work, but even the labor pools didn't want to deal with me. So here I am, begging — can you beat that? Begging for money to buy a bottle of wine so I can forget all the shit that I have to put up with every day. You know, I saw this sign in the window the other day. It said something like "When Life Gives You Lemons, Make Lemonade." I think that pretty much describes me. I'm making lemonade. But don't ask me to drink it. That stuff'll kill you!

To the general public, panhandlers are often characterized as abusers, intent on making a livelihood off the hard-working citizen. This often leads to resentment which, when coupled with an increase in panhandling, has caused many cities to pass ordinances developed to criminalize, or further criminalize, the activities of those who participate in this activity. A much more positive and less costly alternative would be to develop the services and programs needed to aid such individuals. First, there need to be more detox and longer-term substance-abuse programs for the homeless alcoholic and substance abuser, as well as follow-up case management ser-

vices, help with securing entitlements, job training or employment, appropriate alcohol- or drug-free housing, and medical assistance when necessary.¹⁸

Whatever services are developed should also build on the skills the homeless person brings with him — in the case of the panhandler, an entrepreneurial spirit coupled with energy, perception, and innovation. The development of such programs would be, in the long run, more effective in keeping panhandlers off the streets than the current practice of incarceration, with its revolving-door recidivism. Such programs would also be far less costly than incarceration in an already crowded prison system. The result would be financial and social savings to our cities and, perhaps most important, a lifeline to those homeless people who are currently trying to turn lemons into lemonade. ☛

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Notes

1. National Law Center on Homelessness and Poverty, *Go Directly to Jail: A Report Analyzing Anti-Homeless Ordinances* (Washington: National Law Center on Homelessness and Poverty, December 1991).
2. This article concentrates on active begging, or panhandling, rather than on more passive mendicancy. An example of the latter is the practice that is becoming prevalent in many cities of holding up signs that advertise the bearer "will work for food." This activity, which is generally passive in nature, does not appear to cause the concern by local citizens that active panhandling does, nor does begging from one's homeless peers provoke much public concern.
3. Data on panhandling may vary according to the population from which they were gathered (soup line users, service agency clients, or residents in shelters, SROs, or on the streets). Data may also vary depending on how questions regarding mendicancy are phrased (Do you ever beg/panhandle/ask for money from strangers?). Regardless of these variables, available information shows that between 6.8 percent and 24 percent of selected homeless populations admit to practicing some form of mendicancy.
4. Greg Owen and June Heineman, *Results of the Twin City Survey of Emergency Shelter Residents* (St. Paul, Minn.: Wilder Research Center, 1989, 1990), 104 (1989); 109 (1990). Emergency shelter residents were asked, "Did you receive income by asking for money on the street last month?"
5. Martha R. Burt and Barbara E. Cohen, "Sociodemographic Profile of the Service-Using Homeless: Findings from a National Survey," in *Homeless in the United States: Data and Issues*, edited by Jamshid Momeni (New York: Praeger, 1990), 23.
6. Martha R. Burt and Barbara E. Cohen, *America's Homeless: Numbers, Characteristics, and Programs That Serve Them*, Urban Institute Report 89-3 (Washington, D.C.: Urban Institute, July 1989), 43.
7. Merv Goldstein, Stephen Levine, and Robert Lipkins, *Characteristics of Shelter Users* (New York: Adult Services Agency, Bureau of Management Information Systems, Human Resources Administration, City of New York, April 8, 1986), 17.
8. Kathleen H. Dockett, *Street Homeless People in the District of Columbia: Characteristics and Service Needs* (Washington, D.C.: University of the District of Columbia, 1989), 36.

9. Peter H. Rossi, Gene A. Fisher, and Georgianna Willis, *The Condition of the Homeless of Chicago* (Amherst, Mass.: Social and Demographic Research Institute, University of Chicago, September 1986), 88.
10. Roger K. Farr, Paul Koegel, and Audrey Burnam, *A Study of Mental Illness in the Skid Row Area of Los Angeles* (Los Angeles: Department of Mental Health, March 1986), 205.
11. David A. Snow and Leon Anderson, "Identity Work among the Homeless: The Verbal Construction and Avowal of Personal Identities," *American Journal of Sociology* 92, no. 6 (May 1987): 1348.
12. Snow and Anderson have discussed role distancing and embracement in relationship to homelessness in general.
13. "Law Prohibiting Panhandling Repealed in Cincinnati," *Safety Network* 11, no. 1 (January 1992): 4.
14. "Free Speech Protections for Charitable Fund Raising Don't Cover Panhandlers, a U.S. Appeals Court Rules," *Chronicle of Philanthropy* 3 (May 29, 1990): 27-28.
15. Barbara Lubran, "Alcohol-Related Problems Among the Homeless," *Alcohol Health and Research World* 11, no. 2 (Spring 1987): 4.
16. Snow and Anderson, "Identity Work among the Homeless," 1364.
17. *Ibid.*, 1365.
18. Louisa R. Stark, "A Century of Alcohol and Homelessness: Demographics and Stereotypes," *Alcohol Health and Research World* 11, no. 2 (Spring 1987): 13.

Homelessness, Alcohol, and Other Drug Abuse

Research Traditions and Policy Responses

Gerald R. Garrett

Although homeless alcoholics and other drug abusers more often elicit public scorn than sympathy, ironically they enjoy a celebrity status as research subjects. This article provides an overview of research literature on the homeless and their alcohol and drug problems. The evolution of public policies concerning control, rehabilitation, and treatment of homeless substance abusers is also traced with special attention to the interaction between scientific literature and policy responses over the past century. Although homeless populations today are more diverse than their counterparts in earlier decades, the analysis suggests that the policies and programs developed in response to the crisis of homelessness and substance abuse in the 1980s and 1990s reflect themes that are also evident in early literature.

History has not been kind to homeless alcoholics.¹ For more than a century they have collected such labels as winos, degenerate derelicts, morally inferior, and from the Victorian era, whiskey bummers.² As late as the 1960s, newspaper journalists called their habitats a “house of horrors,” their panhandling “The Touch of Terror,” and complained that a “Wave of Bums Sweeps Over Parks, Streets.”³ Nor have other drug abusers — those using cocaine, heroin, more recently crack, ice, and other illegal substances — fared better, even though their presence in large numbers does not appear in homeless populations until the 1960s and early 1970s.

As a Boston police officer complained, “These are your lowest types of homeless street people. They steal, they bum, they prey off others, they spread disease, they commit crimes and they cost taxpayers millions every year!” According to a case manager at a Connecticut shelter, “Drug abusers are our most difficult guests. They are typically on the outs with the law and are very often treatment resistant.” Alcoholics and drug abusers, thus, are probably the least likely of any group in the homeless population to elicit public sympathy. In fact, while recent surveys suggest that not only are some communities losing patience with the plight of the homeless in general, they are even more frustrated when it comes to tolerating the problem behaviors associated with homeless substance abusers.^{4,5}

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In contrast, homeless substance abusers, alcoholics in particular, have for decades enjoyed a celebrity status within the research community. Although their numbers constitute only an estimated 10 percent of the overall population of substance abusers, they have come to be one of the most studied groups in addiction literature.⁶ For more than a century, researchers from a variety of disciplines and clinical fields — psychology and psychiatry, medicine and nursing, political science and public administration, human services and social work, urban planning, education, criminal justice, anthropology, and especially sociology — have in ways elevated homeless alcoholics and drug abusers to a place in scientific literature out of proportion to their representation in the population of substance abusers.⁷

Although a number of reasons — some scientific and theoretical, others pragmatic and humanitarian — account for the disproportionate growth of this body of knowledge, collectively this literature offers policymakers an invaluable information base to inform their decision making. In fact, historically a significant number of studies on homelessness, including those concerning alcohol and drug problems, have been concerted efforts to develop and guide policymaking on urban renewal, rehabilitation services, public housing, human services, public health, law enforcement, and other policy domains.

Because alcohol and other drug problems continue to have an impact on homeless populations, the purpose of this article is to provide an overview of past and recent studies with special reference to how this research literature interfaces with policy responses. Curiously, while contemporary studies identify a “new homeless” that is more demographically diverse, more stratified in the prevalence of health problems, and perhaps even more disenfranchised than its counterpart in earlier decades, it is nevertheless clear that many of the observations and policy recommendations in current literature reflect themes that are evident in the 1950s and earlier. As Howard Bahr points out, “It turns out on inspection that the past *is* relevant after all, although from the typical report on contemporary homelessness one would be led to believe that we confront a totally new situation.”⁸

Epidemiology of Alcohol and Drug Problems

Whatever the differences in today’s homeless population compared to its counterparts in past decades, one problem in particular has remained constant: alcohol and substance abuse. Although early studies reporting prevalence rates of alcohol abuse often utilized unsophisticated methodologies by present standards, overall results have been remarkably consistent over the decades. For example, early studies by McCook (1890) in a national survey, Marsh (1900) in Philadelphia, Cook (1910) in New York, Anderson (1920s) in Chicago, Hoffer (1930s) in California, Straus in New Haven and Stearns and Ullman (both in the 1940s) at Tewksbury, Massachusetts, Caplow (1950s) in Minneapolis, and Bogue (1960s) in Chicago report prevalence rates of alcoholism ranging from a low 28 percent to as high as 57 percent of the homeless population, yet most falling within a 30 to 40 percent range.⁹ While these variations may have been due to population differences by city location, they can also be accounted for by differing methodologies and oftentimes crude definitions of alcohol abuse. Thus McCook took “arrest for public drunkenness” and Hoffer used “confirmed drunkard” as indicative of alcoholism; others

adopted definitions, such as "drink to excess," "steady, excessive consumption," or "heavy drinking."

Ironically, while modern methodologies are far more complicated, their results based on the "new homeless" populations yield almost identical prevalence rates and similar variations to those in early times. Across major U.S. cities, for example, studies of the homeless indicate alcohol abuse or alcoholism prevalence rates from 9 percent in Ohio, 15 percent in New York State, and 25 percent in Los Angeles to 32 percent in San Diego, 35 percent in Portland, Oregon, and 45 percent in Boston.¹⁰ Even within a single city, such as Boston, estimates vary from 25 to 45 percent. Fischer, who has charted and analyzed studies through the 1980s, found that nationwide results on alcohol-related disorders among the homeless show a range of 2 percent to as high as 86 percent.¹¹ As in earlier decades, most estimates cluster in the 30–40 percent range.¹²

Other drug abuse, of cocaine and its derivatives, heroin, and other illegal substances, is also a long-standing problem among homeless people, especially within the past three decades. Both Milburn¹³ and Fischer¹⁴ observed that recent studies provide prevalence estimates ranging from a low of 2 percent to as high as 70 percent (and occasionally higher, depending on study site). Most estimates cluster between 10 and 15 percent.

Current studies show that alcohol and other drug-abuse problems affect a significant number of homeless people. In fact, results from the national Health Care for the Homeless projects, which established a database on homeless clients at clinics in nineteen U.S. cities, identified alcoholism as the most frequent single disorder diagnosed.¹⁵ Moreover, collective evidence suggests that the homeless may have a prevalence rate of alcoholism at least nine times higher than the community at large.¹⁶

Yet it is also clear from recent studies that "dual diagnoses" or comorbidity, that is, the coexistence of substance abuse and mental health disorders, are also prevalent within the homeless population. Fischer and Breakey point out that current research suggests that from one half to three quarters of the homeless population have at least one alcohol/drug/mental health (ADM) disorder. Dual diagnoses, however, show prevalence rates ranging from 2 percent to 34 percent; about one fourth of these evidence an alcohol and mental health disorder and up to one third are diagnosed with concurrent alcohol and drug problems.¹⁷ Less commonly seen among homeless populations in earlier decades, comorbidity, including multiple diagnoses, creates difficult treatment circumstances, especially when alcohol or drug abuse coexists with a psychiatric disorder.

Broad prevalence estimates, however, obscure the subgroups who are most or least affected by substance-abuse and other disorders. This information has particular relevance to policymakers and program planners, since these data help define target groups more clearly. Collective evidence from a number of reports reveals important differences within the homeless population.¹⁸ For example, men are more likely than women to evidence alcohol and drug abuse, though this sex difference is least observed on drugs. The use of drugs is also more commonly seen among younger men than in older age groups (thirty to sixty-four years), who are most likely to be traditional alcoholics resembling those of past generations on skid row. If men are more likely to evidence a single diagnosis of alcoholism, women are more likely to have a single mental disorder. Still other findings document important

differences by psychosocial, race, ethnic, and other demographic characteristics and by service utilization patterns.¹⁹ Thus, while overall evidence suggests that substance abuse remains as the major health problem facing the homeless, as in earlier decades, it is also clear that homeless substance abusers today are more diverse in their composition and rehabilitation needs than ever. As a result, policy and program solutions will require a sensitivity to this diversity and a creativity in their approaches if efforts to return this population to self-supporting, independent, and especially sober lifestyles are to be successful.

Control, Rehabilitation, and Public Policy

Since homeless alcoholics and drug abusers have historically acquired unflattering labels, even public scorn, it is not surprising that efforts to control and later to "rehabilitate" them show a checkerboard evolution that includes cycles of containment to skid row districts; relocation efforts that remove them from their natural habitats into work camps, police farms, poorhouses, and county psychiatric facilities; and more recently various forms of what can be called treatment and rehabilitation. Yet throughout this evolutionary process, it has always been true that homeless substance abusers have been virtually powerless to influence, much less determine their fate at the hands of public policy. In fact, if they have wielded any influence at all over the years, it has typically come in the form of resistance to or avoidance of public programs for their benefit or of becoming uncooperative, if not unruly clients. Even today this form of resistance plagues often well-designed, even creative programs for the homeless. As a defiant homeless substance abuser in a New England city complained, "This [veteran's] program robs me of my self-respect and that paperwork makes me feel like I should get down on my knees begging for help. Never!"

Approaches to controlling and rehabilitating alcohol and drug abuse, however, are historically tied to public views on the causes of homelessness and of substance abuse, as well as to public perceptions of the degree to which the homeless themselves are responsible for their misfortunes and their misbehaviors. This latter point assigns a double stigma to homeless substance abusers, which historically has complicated efforts to formulate and implement viable policies and programs on their behalf. For close to a century, researchers and policymakers alike have debated the role of alcoholism, in particular, as a principal cause of homelessness. Put another way, is alcoholism (and other drug abuse) an antecedent, a concomitant, or a consequence of homelessness? Or is it a combination of all of these? Answers to this question have taken different forms over the past century.

Historical Background

Early policy and program approaches related to homeless substance abusers are closely tied to the issue of vagrancy, one component of which was drunkards. Initial studies by McCook, Marsh, Cook, Anderson, and others,²⁰ are careful to document the proportion of homeless who "drink to excess" or who have been arrested for public intoxication, which functioned to stratify and separate presumed alcoholics from other, more respectable homeless subjects. Regardless, vagrancy (and wanderlust), unemployment, as well as drunkenness, are treated throughout the 1800s and even after the turn of the century as vices. Public policies emphasized

repressive measures that rendered indulgence in these vices costly to the offenders. In 1895, McCook, for example, who was an authority on homelessness in Massachusetts, submitted a proposal to the National Conference of Charities and Correction that would solve the so-called tramp problem by utilizing indeterminate prison sentences, thus keeping them confined until their reformation was completed.²¹ Still others proposed or implemented labor colonies and work-houses.²² In Detroit, for example, "get tough" policies, including forced labor, were well established by the 1880s.²³

But even in this early era there were advocates of rehabilitating the homeless, including those with alcohol problems, that resembled modern understanding of this concept. An advocate for labor colonies, Edmond Kelly nevertheless observed that there must be a balance between rehabilitative and custodial objectives in institutional programs for the homeless. His proposal directed municipal lodging houses to screen clientele so as to identify the honest unemployed men, the unfortunate impoverished, and the "social parasites," which included the drunkards. Each type would receive appropriate rehabilitation.²⁴

During the 1880s, the Salvation Army also brought enlightenment to the American public with its evangelical mission of "effectual help for the drunkard," which has served as its guidepost for more than a century. As Stoil explains, "One crucial component of this effectual help was early recognition by the Salvationists that the repeated cycle of arrest for public inebriation, incarceration in a jail 'drunk tank' or an asylum and subsequent release into the same environment in which public drunkenness was commonplace did nothing to address the self-respect or long-term recovery of the alcoholic."²⁵ Although the public sector was not quick to adopt this principle, it served as a foundation for developing community-based facilities where homeless residents could address their alcoholism, simultaneously developing work skills in an environment of evangelical Christianity. Nor were Salvationists passive in recruiting homeless alcoholics into their facilities, evidenced by the outreach efforts organized by their Bowery Mission. They were conducted on Washington's Birthday and Thanksgiving Day — known as Boozers' Days — when mission officers would comb lower Manhattan in search of public inebriates.²⁶

The Depression Years

Due principally to the onset of the Great Depression, public policies concerning both the homeless and their alcohol and drug problems begin to shift in the 1920s and 1930s toward centralized, more concentrated programs of care. As Bahr notes, "The federal government had moved into the 'treatment of vagrancy' business on a large scale."²⁷ At the same time, the problem of chronic, public inebriates was more evident than ever, and while there emerged both public agencies and private charities to serve the needs of the homeless, few had little to do with alcoholics, that is, other than police and jails.

Moreover, the position of many public spokesmen remained harsh, evidenced by a 1928 paper on "psychopathic vagrancy," which held that breadlines encouraged vagrancy and that vocational programs would not keep derelicts off city streets. Despite its provisions for treatment by psychiatrists, in the end control and rehabilitation of vagrants and public inebriates were left exclusively to police, the courts, and of course jails, since there were not enough psychiatrists to handle other, non-homeless people during the Depression.²⁸

Nevertheless, massive research studies and commission investigations were also hallmarks of this era. Nels Anderson, who had authored an important work in the 1920s, *The Hobo*, chronicled the devastating consequences of the Great Depression in his *Homeless in New York City* and *Men on the Move*, which brought him to a conclusion that a permanent class of homeless people was emerging. In *Twenty Thousand Homeless Men* (1936), Sutherland and Locke observed that Chicago's homeless suffered from multiproblems, including an estimated 10 percent alcoholics and as many as 20 percent afflicted with psychotic disorders. And in 1932, a report from the Illinois Relief Commission's investigation portrayed the hopelessness and despair that cut across all homeless people of that time, pointing to a need to coordinate government efforts at intervention.

Essentially the same results were reported again in 1937, this time calling for integrated, comprehensive programs to assist all homeless, including those with alcohol and other health problems.²⁹ Collectively, these reports suggested that the public image of homeless alcoholics was gradually shifting from "morally inferior derelicts" to one that recognized them as a different type of homeless person requiring special care, even though the police and jails remained their principal caretakers in the years following.

Skid Row and Urban Renewal

Although enclaves of homeless people have sprung up in the form of "hobo jungles," shantytowns, and so-called Hoovervilles throughout the history of urban and rural America, skid row in particular has come to personify the public's image of homeless people and their lifestyles. Its emergence in American cities began in the latter decades of the 1800s, and by the end of the Great Depression, when homelessness reached a peak, virtually every major city had laid claim to a skid row district. In Boston, it became Dover Street; in Chicago it was West Madison Street; in Minneapolis, the Lower Loop; and in New York it was, of course, the famed Bowery. Smaller cities, too — Providence, Richmond, Rochester, Toledo, Sacramento, Spokane — developed skid row districts.

Skid row gets its name not from the cities that have made it infamous, but from Seattle, where it is more commonly called skid road. While its name connotes the downward social mobility associated with homelessness, its origin derives from the skidways used by Seattle's lumberjacks in the 1800s to slide logs to Yesler's Mill on Elliot Bay. Near these routes, but especially at Pioneer Square, saloons, rooming houses, single-room-occupancy hotels, cafeterias, and religious missions sprung up to serve loggers and other clientele. Over time this district collected large numbers of the unemployed, social misfits, and especially alcoholic derelicts.³⁰

While the Great Depression swelled skid row populations nationwide to all-time highs, World War II brought about significant decreases, since younger, able-bodied men went off to war, leaving others to take on jobs that contributed to the war effort. Yet this population decline was short-lived, and during the economic downturn of the 1950s, skid rows became busy, albeit problematic neighborhoods. In fact, most skid rows had become rampant with blight, failed businesses, decrepit, often unoccupied buildings, due to years of neglect and poor city services.

It is no wonder, therefore, that the 1950s helped to focus attention on urban renewal that could enhance the quality of land use. It offered opportunities to increase tax revenues, to reduce if not eliminate nuisance crimes typifying most skid

row neighborhoods, to upgrade the city's image, and especially to attract the middle class back to the city.³¹ But in order to implement urban renewal policies, something had to be done with the homeless people who lived on skid row.

To "solve" this problem, throughout the 1950s and 1960s, many cities enlisted the help of survey researchers, most of them sociologists who had long been attracted to issues on poverty and inner-city life. In Minneapolis, a team of researchers headed by Theodore Caplow began a major study of the redevelopment area and the homeless people who lived there. Supported by a coalition of private businesses in Philadelphia, known as the Greater Philadelphia Movement, Leonard Blumberg and his associates undertook a study of some 2,200 homeless residents in the inner city. Commissioned by the city of Chicago, Donald Bogue undertook a massive study of Chicago's skid row districts, giving special attention to the implications of these data for relocating homeless residents in suitable housing. Detroit, too, undertook a similar endeavor, which was headed by H. Warren Dunham. And in the mid-1960s, federal funds from the National Institute of Mental Health supported a major study of New York's homeless men with Theodore Caplow as principal investigator and Howard Bahr as project director. Later in the 1960s, Bahr and Garrett undertook still another NIMH-funded study on homelessness in New York, this time focusing on homeless women. Known as the Urban Disaffiliation Project, it was the first major study of homeless women.

In all these projects, investigators gave special attention to the problem of substance abuse among the homeless, each reporting similar prevalence rates for skid row men. While they were not the first to study homeless alcohol and drug abusers, the comprehensive scope of these studies generated large amounts of quantitative, even qualitative data that could be infused rapidly into research literature on substance abuse and other disciplines. Despite their applied research approach, these studies represent substantial pieces of scholarship that provided comprehensive, detailed information about the homeless and their substance-abuse problems. Moreover, because most of these studies were commissioned or funded by city, state, or federal government sources for specific purposes, their findings helped to inform their immediate audience comprised of policymakers, government administrators, and professional personnel about the alcohol and drug problems of homeless people.

Large survey studies were not the only pieces of important scholarship during the 1950s and 1960s. Ethnographic works by Peterson, Rooney, Spradley, and especially Rubington offered rich insights into the subculture of homeless alcoholics, including their experiences in jails, drunk tanks, and rescue missions, as well as on the group dynamics of "bottle gangs" and communal circumstances in bars and skid row hotels. Later Wiseman contributed a particularly significant work that explains how skid row alcoholics assign meaning to events in their repetitive cycles through the criminal justice system, spiritual missions, treatment facilities, and other institutions.³²

That alcohol and drug problems of the homeless achieved higher visibility during this era is also evident by professional meetings convened around the issue. In September 1955, the first annual International Institute on the Homeless Alcoholic was convened in Detroit. Its proceedings help to document a link between research and clinical literature on alcoholism among the homeless to policymakers and public administrators. Considering the emphasis on urban renewal in the 1950s, no article is perhaps more germane than that of Arthur Stine, "Rehabilitation of the Alcoholic

and What It Means to the Taxpayer!"³³ Though renamed and relocated in subsequent years, its proceedings are evidence that programmatic and treatment approaches, especially, were central concerns. Of particular note from the second conference in 1956 was the article written by Morris Chase — then a bureau director in the New York City Department of Welfare — "The Homeless Woman Alcoholic," about his concerns that more women alcoholics could be expected to enter the ranks of the homeless.³⁴ A little more than a decade later, data collected in Bahr and Garrett's study of homeless women in New York proved that he was absolutely correct!³⁵

Public Inebriates and the Police

Throughout the history of skid row, police have had a "special relationship" with homeless alcoholics! On the one side, police served as caretakers, though never in the conventional sense. During the heyday of skid row, police protected homeless people by "moving them on" so that they might avoid a "pinch" or seek safe haven from the elements at a mission, shelter, or even an abandoned building. Protecting public inebriates from victimization, especially from "jackrolling" or robbery, is still another, though rarely successful service. Even the routine police sweeps when public drunks were rounded up and jailed, known in police jargon as "preventive arrests," had its benefits during cold winter months, since it provided inebriates with a safe place to sleep off their liquor, three "square meals," and a cot!³⁶ In this respect, homeless alcoholics have enjoyed a benevolence that police have never extended to homeless drug abusers, at least in quite the same way, partly because their illicit activities more often involve felony infractions rather than the misdemeanors typical of public inebriates.

On the other side, the peace-keeping role of police served a containment function, keeping skid row residents, especially public inebriates, in their place. In virtually all skid row police precincts, unofficial police policy awarded officers wide discretion to exercise their containment role.³⁷ Curiously, as urban renewal began to achieve its development goals in the 1960s and 1970s, its success helped to disperse ecological concentrations of homeless people from skid row, thus breaking down the containment effect. This breakdown in part explains the extraordinary visibility of homeless people in most urban centers in the 1980s and 1990s.

Court Decisions

If there is a single hallmark in the history of scientific literature on alcohol and drug addiction, it is certainly E. M. Jellinek's classic volume, *The Disease Concept of Alcoholism*. Beginning in the 1940s, Jellinek's work helped set in motion the concept that alcoholism was a disease involving a configuration of social, psychological, and medical symptoms, including dreaded alcohol-related ailments such as liver disease and pancreatitis. While the disease concept has had major impact on research and clinical literature, public sentiments about alcoholism also began to change. The dramatic growth and success of Alcoholics Anonymous, which got its start in the 1930s, played a major role in changing public attitudes about the causes of alcoholism and in lessening the public stigma assigned to alcoholics.

By the 1960s, however, growing public acceptance of the disease concept served as an impetus that led to important landmark court decisions concerning public inebriates and vagrancy. In *Robinson v. California* (1962), the U.S. Supreme Court

ruled that drug addiction was not per se a punishable offense when the drug user was "diseased and lacked volition in regard to drug use." This enabled two important arguments to come into play: the cruel and unusual punishment doctrine contained in the Eighth Amendment and the precept that "a person cannot be punished for an involuntary act."³⁸

Subsequently *Easter v. District of Columbia* (1966) and *Driver v. Hinnant* (1966) ruled in favor of defendants charged with public intoxication. Although the *Easter* decision applied only to the District of Columbia, the Circuit Court of Appeals ruled unanimously that the disease of alcoholism is a permissible defense in cases involving public drunkenness. Since alcoholism involved a "loss of control" syndrome, Easter, who was a long-standing alcoholic, could not be held accountable for his crime. In the *Hinnant* decision, rendered by the U.S. Court of Appeals, Fourth Circuit, the court reasoned that Hinnant, a skid row alcoholic who had spent two thirds of his adult life in jail for vagrancy and public drunkenness, should be exempted from criminal sanctions. Although a later Supreme Court case, *Powell v. Texas*, specifically addressed the significance of the disease concept of alcoholism, the Court did not rule in favor of the defendant, largely because testimony on his behalf was "utterly inadequate." Nevertheless, this decision represents an important step in the evolution of legal changes concerning public drunkenness, since four of the five justices who upheld Powell's conviction agreed that since there was no known effective treatment for alcoholism and a deficiency of treatment facilities, a jail sentence outweighed the benefit of an indeterminate civil commitment for treatment.³⁹

The Uniform Alcoholism Treatment Act

Ironically, while the *Powell* decision seemingly upheld the traditional punishment perspective on public drunkenness, the reasoning underlying the Court's ruling can be seen as writing a script that contributed to the groundwork for legislation passed by Congress in 1971. Known as the Uniform Alcoholism and Intoxication Treatment Act, this legislation defined a continuum of medical services as an alternative to criminal justice processing of drunkenness offenders, thus encouraging states to decriminalize public drunkenness laws. This act was seen as having its greatest impact in skid row districts, where homeless alcoholics had for decades clogged court dockets and overcrowded city jails at enormous cost to taxpayers. In fact, it was not uncommon for some homeless chronic alcoholics to spend more than six months a year in jails and drunk tanks, which Pittman and Gordon described as a "revolving door" phenomenon.⁴⁰

Although there was widespread consensus in the professional community that treatment was a more humane approach than criminal justice processing of drunkenness offenders, the act did not contain concrete provisions for establishing detoxification and treatment centers. As an impetus to adopt and implement the act, Congress in 1974 passed the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act which provided federal funding to establish treatment facilities. Maryland and Massachusetts were among the first to develop this treatment-oriented model; most other states eventually adopted the act.⁴¹

Networks of detoxification and medical units for treating public inebriates are now in place nationwide. While these have ultimately helped to unclog municipal court dockets (only to be replaced by the proliferation of drug-involved offenders in the 1980s and 1990s), another form of "revolving door" seems to have appeared.

Fagan and Mauss, for example, suggest that detoxification centers have created a new version of recidivism in which patients pass from one public detox unit to the next, often at heavy cost to taxpayers.⁴² Others, too, have made similar observations. In the study of homeless women during the 1970s, for example, Garrett notes that nearly half of a sample of fifty-seven skid row women spent an average of 275 days in hospitals and medical care and residential care facilities, most in and around New York City.⁴³ Neuner and Schultz tracked forty-three chronic alcoholic recidivists from Hennepin County, Minnesota, through the treatment and criminal justice systems over a year-long period. Using outcomes from this sample to project costs for services to the county's estimated 425 homeless chronic alcoholics, they concluded that taxpayers should expect to foot a bill of *at least* \$10 million per annum!⁴⁴

Detoxification units, however, were never intended to be the ultimate treatment for alcoholics and drug abusers. Instead, they serve as one of several intercept points that provide patients with potential avenues into long-term recovery programs, that is, once sobriety is restored. For those with adequate health care insurance to defray treatment costs, the issue is more their motivation to seek treatment than their ability to pay. However, homeless substance abusers, even when they are motivated and committed to their recovery, have far fewer options, since they rarely enjoy the privileges of medical insurance. Sustaining their recovery efforts thus involves reliance either on public treatment facilities or on the generosity of state funding to support treatment in private facilities under purchase-of-service arrangements. In periods of budget decline, a reality of the 1990s in virtually every state, funding for human and health services is often among the first to be sliced.

The Stewart B. McKinney Act

The crisis of homelessness has been shaped by a combination of policy factors spanning at least three decades. Urban redevelopment policies displaced thousands of homeless people from their skid row habitats. In the 1970s, for example, as many as one million SRO units were eliminated while housing prices escalated and subsidies for public housing declined. In the 1980s, income supports were eroded by both inflation and changing policies on entitlements and welfare benefits. The Community Mental Health Act of 1963 helped to stimulate a deinstitutionalization movement that brought about a 73 percent reduction in the number of patients in state psychiatric hospitals between 1959 and 1980, a significant number of whom became homeless with no psychiatric care.⁴⁵ Collectively these policy changes, along with other social factors, played a major role in stimulating vast increases in the size of the homeless population during the 1980s, estimated by some to be as high as 3 million.⁴⁶

In response to this crisis, Congress signed into law the Stewart B. McKinney Homeless Assistance Act on July 22, 1987. Although the act does not directly address the causes of homelessness, its purpose is to provide federal leadership in implementing comprehensive assistance programs for the nation's homeless.⁴⁷ Coordinating this effort is the responsibility of the Interagency Council for the Homeless. In fiscal year 1992, McKinney appropriations total \$871.6 million; \$129.9 million is appropriated for non-McKinney homeless assistance programs.

Although numerous programs were established by the McKinney Act, including those focusing on mental health, job training, adult education, emergency food and shelter, housing, and others, the Community Demonstration Grants Projects for Alcohol and Drug Abuse Treatment of Homeless Individuals specifically addressed

the needs of homeless substance abusers. Administered by the National Institute on Alcoholism and Alcohol Abuse (NIAAA) in consultation with the National Institute on Drug Abuse (NIDA), the mission of the demonstration project was to develop and evaluate community-based approaches to treatment. Auxiliary objectives included facilitating linkages with other human service and treatment agencies, increasing access to shelter and housing, and improving the economic and quality-of-life factors for homeless people.⁴⁸

In 1988, the Community Demonstration Grant Projects funded projects in nine cities: Anchorage, Boston, Los Angeles, Louisville, Minneapolis, Oakland, New York, and two in Philadelphia. Although all these projects have common components, their approaches were guided by their individual treatment philosophies and configured around circumstances of their target populations and local treatment resources.⁴⁹

Although these projects concluded in mid-1991, detailed reports of their results are not yet available.⁵⁰ However, it is noteworthy that the demonstration projects allocated 25 percent of their budgets to carry out their evaluation plans. In addition, data from these projects were collected by a national evaluation team. Taken together, the Community Demonstration Grant Projects will yield comprehensive data about alcohol and drug abuse among homeless people, invaluable information about the efficacy of treatment approaches, and viable strategies for facilitating sober living environments and reintegrating recovering substance abusers in the community.

While the Community Demonstration Grant program represents an unprecedented benchmark in the history of research on homeless substance abusers, as well as in developing creative intervention approaches, fourteen new projects were funded by the NIAAA in September 1990. Under its Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons, awards were made to cities located in all geographic regions of the United States.⁵¹

Housing and Sober Living

While solutions to the crisis of homelessness involve much more than generating affordable housing, the fact is that shelter is precisely what the homeless do not have. As a homeless woman in Hartford explained, "I have no shelter, no home, and no place to go!" Overall efforts to assist the homeless must therefore provide opportunities for housing.

For the homeless recovering from alcohol or drug dependency, however, locating suitable housing can be even more complicated, since sustaining sobriety often hinges on alcohol- and drug-free living environments. Historically, this need has been consistently overlooked by rehabilitation programs for homeless alcoholics and other drug abusers. As far back as 1960, for example, New York's well-regarded Camp LaGuardia offered alcoholics and other homeless men the luxuries of fresh air, exercise, work programs, three square meals, and social services. Yet with no housing opportunities to pursue after their release, more times than not these men returned to the environment most familiar to them, the Bowery, where it was next to impossible to sustain sobriety in the permissive drinking subculture. Essentially the same circumstances are true of many homeless substance abusers today, who cycle in and out of public detox centers, each time returning to the living arrangements

that supported their alcohol or drug abuse in the first place. So alcohol- and drug-free housing plays a critical role in sustaining the recovery process and establishing sober living habits.

In his extensive work on housing issues, Wittman points out that restoring the affordable housing stock is the main focus of efforts to house homeless people. There are different types of housing opportunities: regular housing, such as single- or multifamily units, duplexes, and apartment buildings; single-room-occupancy (SRO) and specialty housing; and institutional housing. Since there is "nothing special" about the first of these categories, it need only be said that single-family units are as viable for recovering substance abusers as they are for others who have been assisted out of homeless circumstances, since needed recovery services can be acquired at off-site sources.⁵²

SRO units are intended to house single adults and specialty housing is designed to accommodate groups with special needs, such as recovering substance abusers or those who suffer from psychiatric disorders. Both types of housing achieve their efficiency through shared facilities. In recent years, renovated SRO hotels have become an important, low-cost housing source that can be ideally suited to the needs of those in recovery. For example, San Francisco's Arlington Hotel is one of ten SRO hotels established by the Mayor's Task Force on Public Inebriates. Operating under an alcohol/drug management policy, the Arlington Hotel serves as an "island of sobriety" for men and women in recovery. In addition, SRO hotels and special housing in the form of a "boardinghouse" operate according to policies similar to SRO alcohol/drug-free facilities. These boardinghouses are often reconfigured from single-family houses so they can accommodate residents in communal living.⁵³

Although relatively few recovering alcohol/drug abusers require institutional housing like hospitals and nursing homes, these types of facilities offer housing options that provide relatively comprehensive care. They are part of the continuum of housing options that can benefit a small percentage of homeless substance abusers requiring supervision and domiciliary care.⁵⁴

One of the most promising programs for generating alcohol/drug-free housing is the Oxford House model. The operation of Oxford House, founded in 1975 by residents of a halfway house, is guided by democratic decision making and several straightforward, commonsense rules that must be followed by its tenants, all of whom are recovering substance abusers. Self-supported and self-managed by their current residents, more than 250 Oxford Houses are now in operation nationwide. A 1988 provision in the Omnibus Drug Act required states to develop a revolving fund for making loans to qualified applicants seeking to establish Oxford Houses.⁵⁵ In sum, while the Oxford House model may not be the singular solution to meeting the housing requirements of recovering substance abusers, policymakers must respect the importance of alcohol/drug-free living environments to sustaining sobriety and the recovery process.

This chronicle of literature about homelessness and alcohol and drug abuse offers only highlights of some of the more important benchmarks in this research tradition. Nevertheless, it is clear that the evolution of these researches interacts with policy-making concerning homelessness and substance abuse. This is particularly true beginning in the 1950s, when large survey studies were sponsored by agencies which sought answers to questions and problems that would guide their policymaking. The

NIAAA/NIDA Community Demonstration Grant Projects, however, hold unusual promise of yielding valuable information about the efficacy of intervention and treatment approaches, viable options for sustaining long-term recovery, even strategies for stimulating the housing stock. And because the Community Demonstration Projects include extensive evaluation plans enabling them to document implementation procedures and assess treatment outcomes, it should be possible to replicate approaches identified as successful in comparable agencies serving homeless alcohol and drug abusers. If so, the Community Demonstration program will have written the single most important chapter in this research tradition on homelessness and substance abuse. ☛

Notes

1. Selected segments of this manuscript are an elaboration of materials from an earlier work: Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 301–32. For an expanded discussion of many of the points covered, see Russell K. Schutt and Gerald R. Garrett, *Responding to the Homeless: Policy and Practice* (New York: Plenum Publishers, 1992), chap. 5, 6; and Gerald R. Garrett and Russell K. Schutt, *Working with the Homeless*, 3d ed. (Boston: Center for Communications Media, 1990).
2. Jim Baumohl, "Alcohol, Homelessness, and Public Policy: Editor's Introduction," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 281. Baumohl notes that "whiskey bummers" functioned as a crude "social diagnosis" to distinguish alcoholic tramps from the more reputable unemployed who upheld personal virtues while down on their luck. See Baumohl's brief yet informative discussion on 282–83.
3. See Howard M. Bahr, *Skid Row: An Introduction to Disaffiliation* (New York: Oxford University Press, 1973), 58–61. Despite countless acts of charity and dozens of new state and federal programs aimed at helping the nation's homeless in the past decade, such newspaper accounts are in fact appearing again in the 1990s. During the 1991 World Series, for example, newspaper accounts document that Atlanta's police quietly swept away the homeless from city streets, especially unsightly and bothersome alcoholic derelicts. Newspaper accounts indicate that in San Francisco, former police chief Frank Jordan made his "get tough on the homeless" approach a campaign issue in the 1991 mayoral election. Newspapers such as *USA Today*, the *New York Times*, *Boston Globe*, and the *Seattle Post-Intelligencer* report that the "streets are meaner" for the homeless. See, for example, Andrea Stone, "For Homeless, Streets Are Meaner," *USA Today* (November 25, 1991), 3-A. See also note 5.
4. U.S. Conference of Mayors, *Report on Homelessness* (Washington, D.C., 1991).
5. Seattle is a good case in point. Long tired of countless homeless beggars in the downtown shopping district, merchants have taken to posting signs that inform shoppers that panhandling supports substance abuse, advising them to give instead to their favorite charities. As a merchant who owns a gift shop near Pioneer Square explained to me, "These street homeless are aggressive, they come after you. This is not 'Buddy, can ya spare me a dime?' — This is 'Gimme your change!' And if you don't, be prepared for insults or worse!" Because of assaults on pedestrians by homeless panhandlers, Seattle's police vigorously enforce "open container and public consumption" ordinances, particularly in Pioneer Square — ironically the district from which "skid road" derives its name.
Yet Seattle is not alone in expressing its public frustration over the legions of street homeless. During the latter years of Mayor Edward Koch's administration in New York, the mayor himself publicly urged New Yorkers to give to charities for the homeless, but not to panhandlers, which he and others felt supported substance abuse. In Atlanta, Denver, and Detroit, city ordinances intended to curb aggressive begging and "open-air sleeping" have been proposed or passed. Police in Santa Monica, California, which has attracted thousands of home-

less people to its oceanside park, now enforce a ban on sleeping in the park from midnight to dawn. And in recent years, Los Angeles, Detroit, and New York have closed or bulldozed shantytowns. Still other communities and their local merchants have gone so far as to offer bus tickets for the homeless to leave town!

6. Garrett, "Alcohol Problems and Homelessness," 302-3.
7. For a comprehensive review of scientific literature on alcohol and drug abuse among homeless people, see *ibid.*; Russell K. Schutt and Gerald R. Garrett, "The Homeless Alcoholic: Past and Present," in *Homelessness: The National Perspective*, edited by Marjorie J. Robertson and Milton Greenblatt (New York: Plenum Publishers, 1992); Dennis McCarty, Milton Argeriou, Robert B. Heubner, and Barbara Lubran, "Alcoholism, Drug Abuse and the Homeless," *American Psychologist* 46, no. 11 (November 1991): 1139-48; M. Susan Ridgely, Caroline T. McNeill, and Howard H. Goldman, *Alcohol and Other Drug Abuse Among Homeless Individuals: An Annotated Bibliography* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1988); Louisa Stark, "A Century of Alcohol and Homelessness: Demographics and Stereotypes," *Alcohol, Health and Research World* 11, no. 3 (Spring 1987): 8-13; U.S. Department of Housing and Urban Development, *Publications Relating to Homelessness: A Working Bibliography* (Washington, D.C.: Office of Policy Development and Research, 1989). See also Howard M. Bahr, *Disaffiliated Man: Essays and Bibliography on Homelessness* (Toronto: University of Toronto Press, 1970); V. Mulkern and R. Spence, *Alcohol Abuse/Alcoholism among Homeless Persons: A Review of the Literature, Final Report to NIAAA* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1984); Friedner Wittman, ed., *The Homeless with Alcohol-related Problems: Proceedings of the NIAAA Meeting to Provide Research Recommendations* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1985); Jim Baumohl, ed., *The Homeless with Alcohol Problems* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1986); NIAAA, *Homelessness, Alcohol and Other Drug Abuse* (Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism/University of California, San Diego, Program on Alcohol Issues, 1988). At least three professional journals in recent years have devoted thematic editions exclusively to alcohol, drug abuse, and homelessness: *Alcohol, Health and Research World* 11, no. 3 (Spring 1987); *Contemporary Drug Problems* 16, no. 3 (Fall 1989); *Alcoholism Treatment Quarterly* 7, no. 1 (1990). A thematic edition on alcohol and homelessness by the *Journal of Studies on Alcohol* is in the planning stages.
8. Howard M. Bahr, "Introduction," in *Homelessness in the United States: State Surveys*, vol. 1, edited by Jamshid Momeni (Westport, Conn.: Greenwood Press), xx.
9. J. J. McCook, "A Tramp Census and Its Revelations," *Forum* 15 (1983): 753-66; B. Marsh, "Causes of Vagrancy and Methods of Eradication," *Annals of American Academy of Political and Social Sciences* 67 (1904): 2445-56; H. Cook, *Report of the Secretary of the Municipal Lodging House for October, 1910* (New York: New York Charity Organization Society, 1910); Nels Anderson, *The Hobo* (Chicago: University of Chicago Press, 1923); E. Hoffer, *The Ordeal of Change* (New York: Harper & Row, 1964); Robert Straus, "Alcohol and the Homeless Man," *Quarterly Journal of Studies on Alcohol* 7 (1946): 360-404; A. W. Stearns and A. D. Ullman, "One Thousand Unsuccessful Careers," *American Journal of Psychiatry* 105 (1949): 801-10; Theodore M. Caplow, Keith Lovald, and Samuel A. Wallace, *General Report on the Problem of Relocating the Population of the Lower Loop Redevelopment Area* (Minneapolis: Housing and Redevelopment Authority, 1958); Donald J. Bogue, *Skid Row in American Cities* (Chicago: Community and Family Study Center, University of Chicago, 1963).
10. D. Roth and J. Bean, "Alcohol Problems and Homelessness," *Alcohol, Health and Research World* 10, no. 2 (Winter 1985/86): 14-15; New York State Department of Social Services, *Homelessness in New York State: A Report to the Governor and Legislature* (Albany: State of New York, 1984); R. Ropers and M. Robertson, *The Inner-city Homeless in Los Angeles: An Empirical Assessment* (Los Angeles: Los Angeles Basic Shelter Project, 1984); J. Wynne, *Homeless Women in San Diego: A New Perspective on Poverty and Despair in America's Finest City* (San Diego: County of San Diego, Department of Health Services, Alcohol Program, 1984); Multnomah County Social Services Division, *The Homeless Poor* (Portland, Oreg.: Division of Social Services, 1984); G. R. Garrett and R. K. Schutt, "Homelessness in

- Massachusetts: Description and Analysis," in *Homelessness in the United States*, 79–90; Massachusetts Association for Mental Health, *Homelessness: Organizing a Community Response* (Boston, 1983).
11. Pamela J. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems in the Contemporary Homeless Population: A Review of the Literature," *Contemporary Drug Problems* 12, no. 3 (Fall 1989): 333–89. See also Pamela J. Fischer and William R. Breakey, "The Epidemiology of Alcohol, Drug, and Mental Health Disorders Among Homeless Persons," *American Psychologist* 46, no. 11 (November 1990): 1115–28.
 12. Garrett and Bahr analyzed data gathered on drinking behavior from several samples of homeless men and women in New York City. Although their overall results show that women may be more "truthful" in reporting their drinking than men, they also suggest that "sophisticated" quantitative measures of drinking may not be better than simple, straightforward self-reports, or at least they do not yield substantially different results. See G. R. Garrett and H. M. Bahr, "A Comparison of Self-report vs. Quantity-frequency Classifications of Drinking," *Quarterly Journal of Studies on Alcohol* 35 (December 1974): 1294–1306.
 13. Norweeta Milburn, "Drug Abuse Among the Homeless," in *Homelessness in the United States: Issues and Data*, vol. 2 (Westport, Conn.: Greenwood Press, 1990).
 14. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems."
 15. J. Wright and E. Weber, *Homelessness and Health* (New York: McGraw-Hill, 1987).
 16. Fischer, "Estimating the Prevalence of Alcohol, Drug and Mental Health Problems."
 17. Fischer and Breakey, "The Epidemiology of Alcohol, Drug, and Mental Disorders," 1115–16.
 18. Ibid.; Milburn, "Drug Abuse Among the Homeless"; Institute of Medicine, *Homelessness, Health, and Human Needs* (Washington, D.C.: National Academy of Medicine, 1988); Schutt and Garrett, "Homelessness in Massachusetts"; Wright and Weber, *Homelessness and Health*; McCarty et al., "Alcoholism, Drug Abuse and the Homeless"; Fischer, "Estimating the Prevalence of Alcohol and Drug Disorders"; Paul Koegel and A. Burnham, "Traditional and Nontraditional Homeless Alcoholics," *Alcohol, Health and Research World* 11 (Spring 1987): 28–34.
 19. Wright and Weber, *Homelessness and Health*; Koegel and Burnham, "Traditional and Non-traditional Homeless Alcoholics"; Schutt and Garrett "Homelessness in Massachusetts"; Fischer and Breakey, "The Epidemiology of Alcohol, Drug, and Mental Health Disorders."
 20. See note 9.
 21. Bahr, *Skid Row*, 222–25.
 22. Garrett, "Alcohol Problems and Homelessness"; Stearns and Ullman, "One Thousand Unsuccessful Careers"; Bahr, *Skid Row*, chap. 7.
 23. Bahr, *Skid Row*, 224.
 24. Ibid.
 25. Michael Stoil, "Salvation and Sobriety," *Alcohol, Health and Research World* 11, no. 3 (Spring 1987): 14
 26. Ibid.
 27. Bahr, *Skid Row*, 224–25.
 28. Ibid., 225–26.
 29. Nels Anderson, *The Hobo* (Chicago: University of Chicago Press, 1923), *Homeless in New York City* (New York: Board of Charity, 1934), and *Men on the Move* (Chicago: University of Chicago Press, 1940); Edwin Sutherland and Harvey Locke, *Twenty Thousand Homeless Men* (Chicago: J. B. Lippincott, 1936); Illinois Relief Commission, *Men in the Crucible* (Chicago, 1932); Glenn Johnson, *Relief and Health Problems of Selected Group of Non-family Men* (Chicago: University of Chicago Press, 1937).

30. Garrett, "Alcohol Problems and Homelessness."
31. Ibid.
32. James Rooney, "Group Processes Among Skid Row Winos," *Quarterly Journal of Studies on Alcohol* 22 (1961): 444-60; James Spradley, *You Owe Yourself a Drunk* (Boston: Little Brown, 1970); Earl Rubington, "The Bottle Gang," *Quarterly Journal of Studies on Alcohol* 29 (1968): 943-55; Jacqueline P. Wiseman, *Stations of the Lost* (Englewood Cliffs, N.J.: Prentice-Hall, 1970).
33. *The Homeless Alcoholic: Proceedings of the First Annual International Institute on the Homeless Alcoholic* (Detroit: Detroit Mayor's Rehabilitation Committee on "Skid Row" Problems and the Michigan State Board on Alcoholism, September 1955).
34. *Proceedings of the Institute of the Skid Row Alcoholic* (New York: National Committee on Alcoholism, March 1956).
35. Howard M. Bahr and Gerald R. Garrett, *Disaffiliation Among Urban Women* (New York: Columbia University, Bureau of Applied Social Research, 1972); Gerald R. Garrett and Howard M. Bahr, "Women on Skid Row," *Quarterly Journal of Studies on Alcohol* 34 (December 1973): 1228-43; Howard M. Bahr and Gerald R. Garrett, *Women Alone* (Lexington, Mass.: Lexington Books, 1976).
36. Egon Bittner, "The Police on Skid Row: A Study of Peace Keeping," *American Sociological Review* 32 (October 1967): 699-715.
37. Ibid.
38. For a superior summary and analysis of major court cases concerning public intoxication during this period, see N. Kurtz and M. Regier, "The Uniform Alcoholism and Intoxication Treatment Act," *Quarterly Journal of Studies on Alcohol* 36 (1975): 1421-41. During the Johnson administration, the President's Commission on Law Enforcement and Administration of Justice was established as a task force to look into issues concerning crime, delinquency, corrections, and drunkenness. See *Task Force Report: Drunkenness* (Washington, D.C.: U.S. Government Printing Office, 1967); Richard J. Driver, "The United States Supreme Court and the Chronic Drunkenness Offender," *Quarterly Journal of Studies on Alcohol* 30 (March 1969): 242.
39. Kurtz and Regier, "Uniform Alcoholism Act."
40. David Pittman and C. Wayne Gordon, *The Revolving Door: A Study of the Chronic Police Case Inebriate* (Glencoe, Ill.: Free Press, 1958).
41. Kurtz and Regier, "Uniform Alcoholism Act."
42. Garrett, "Alcohol Problems and Homelessness."
43. Gerald R. Garrett, "Drinking on Skid Row: The Case of the Homeless Woman." Presented at the annual meetings of the American Sociological Association, New York, August 1973.
44. R. Neuner and D. Schultz, *Borrow Me a Quarter* (Anoka: Minnesota Institute of Public Health, 1986).
45. Schutt and Garrett, *Responding to Homelessness*, 3-9.
46. Anna Kondratas, "Ending Homelessness: Policy Challenges," *American Psychologist* 46, no. 11 (November 1991): 1226.
47. For further information about the McKinney Act, see Garrett and Schutt, *Working with the Homeless*, chap. 7. For an analytical discussion of this act, see Kondratas, "Ending Homelessness," 1226-31, and Maria Foscarinis, "The Politics of Homelessness: A Call to Action," *American Psychologist* 45, no. 11 (November 1991): 1232-38.
48. Gerald R. Garrett and Robert B. Heubner, "Alcohol, Drugs and the Crisis of Homelessness: Challenge to the Criminal Justice System." Presented at the annual meetings of the Academy of Criminal Justice Sciences, Washington, D.C., March 1989.

49. For a brief summary of the Community Demonstration Grant Projects, see the *Alcoholism Treatment Quarterly's* thematic issue, "Treating Alcohol and Drug Abuse Among Homeless Men and Women: Nine Community Demonstration Grants," Milton Argeriou and Dennis McCarty, eds., vol. 7, no. 3 (1990), and McCarty et al., "Alcohol, Drug Abuse, and the Homeless," 1143-44.
50. See *ibid.*
51. For project locations and an overview of the Cooperative Agreement Program, see NIAAA, *Synopses of Cooperative Agreements for Research Demonstration Projects on Alcohol and Other Drug Abuse Treatment for Homeless Persons* (Rockville, Md.: NIAAA).
52. Friedner D. Wittman, "Housing: From Street, to Shelter to ———?" in Russell K. Schutt and Gerald R. Garrett, *Responding to the Homeless: Policy and Practice* (New York: Plenum Publishers, 1992), 193-98.
53. Wittman, "Housing."
54. *Ibid.*
55. *Ibid.*

My Name Is Edward, I Am an Alcoholic

Edward Baros

While I was still a baby my Grandmother adopted me. I was born into a family of 12 sisters but I really hurt because my mother and father did not want me. On my 10th birthday, my sister and a friend came over while my grandmother was shopping. I was outside playing basketball, when my sister called me in to play a game. First they tied me to the bed, took my clothes off and had sex with me. I tried to get loose but my legs and arms were hurt with the ropes.

When I told my Grandmother about it she hit me on the head with a 2 by 4. At the hospital the doctor believed me and called the police who arrested my sister and her friend. The court gave them five years but that does not stop the nightmares still on my birthday.

I first learned to drink when I was 16 when my father taught me with beer and whisky. I was a heavy drinker from 16 til I was 21. My next nightmare was when I was 18. I went hunting with a friend. I was only drinking beer, but he was taking "angel dust" but I didn't have any.

We were walking on top [of the] train track bridge with me leading in front. I turned around just as he shot himself in the head and fell in the water. I called to my house to get help. I couldn't talk and was in shock when I saw the blood on my clothes. I called the police and an ambulance was called too. He was pronounced dead. We had to inform his parents about what happened. This hurt me and still does sometimes.

When I was 21 I was kicked out of my grandmother's home. I lived on the street for ten months. I was lucky to have had a friend who bought me food and beer everyday. The day my grandmother went to the hospital I was in jail. Someone put a "micky" in my drink, I was even knocking [down?] doors. It was best that she didn't know I was in jail. I was given 30 days by the court. Of course, one of them was my birthday.

While I was in jail my grandmother died and I was released to my uncle. At the reading of my grandmother's will, my uncle and aunt decided to help because my grandmother had left me \$2,000. After I moved [into] my uncle and aunt's house, they kicked me out and back on the street. I went to a group home in Wyoming. I met [my] wife. When we broke up, I wanted to die, but they found me in time.

While I was in Wyoming, my sister came to visit from Rhode Island. After meeting my wife she said if I ever need a place, to come to see her. One day my wife and I had

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a big fight. [I was] thrown up against the wall. I didn't need that. With only my clothes, some borrowed money from my uncle, I rode the bus from Wyoming to here.

When I first arrived, I got help from the James L. Maher Center. I went to work and worked on the Navy Base for 5 years. When I moved into 50 Washington Square I met David Mehl. I changed jobs and started working for them and living in a nice apartment.

All the time I lived with my grandmother, uncle, aunt, sister, I was a lonely person and felt no one cared for me. Everything was fine til I got into an argument with a girl I thought I loved and started to drink again. When I drink and drink I am hateful to myself and others. I also get angry a lot and bang my head up against the wall.

I was banging my head on the floor when someone called rescue and I went to Newport Hospital, where I stayed overnight. When I drink it makes me not want to live. When I was discharged my counselor asked me if I wanted to go into treatment. I agreed to go to the Good Hope Center. I am glad to have someone like her to care for me.

To everyone at the Good Hope Center I want to say "Thank you." You helped me to open my eyes better and be happy! When [I came back I] didn't want to come out of my bedroom, it took me two days, but I am so glad to be back at work.

This always [seems to happen? when I] meet someone that can share time with me and I can care for her. I just don't want to be lonely again. I've never been on a date with a lady. 2.

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Subgroups of the Homeless

Street Kids

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Street kids are a feature of many cities, but only recently have they been included among the homeless. They were defined as runaways, throwaways, or youth in crisis. They had a place to live, even if it was a foster or group home or an institutional setting. However, many are without shelter at one time or another and face the same problems as the chronic homeless: the need for food and shelter, avoidance of victimization, and help for personal problems. In 1988, the National Institute of Mental Health funded three national demonstration projects on adolescent homelessness. We report findings from one of those, in Portland, Maine. The focus was individual, organizational, and systemic dimensions of the problem and how public policy can be responsive to the needs of this subgroup of the homeless.

Homelessness faces many different subgroups in the population. Before the 1980s, it was primarily a characteristic of older males, usually with drinking problems. They inhabited the skid rows and railyards of the nation. Over the next decade, social trends combined to create a much larger number of homeless and added entirely new groups. The deinstitutionalization of large state mental hospitals, which began in the 1960s, put many individuals on the street. A large percentage had serious mental health problems and minimal independent living skills. The Reagan era cutbacks in social services, particularly in the area of public housing, added a new homeless group: families with children. Owing to higher divorce rates, AFDC regulations, and the difficulty of maintaining the nuclear family in inner-city areas, many of the households were headed by females. These families represented the increasing "feminization of poverty."¹

Children are usually discussed within the context of homeless families. They range in age from infancy to their early teens. By the late 1980s, one third of the homeless

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population were family members. Children constituted the fastest growing group among them.²

There is another subpopulation of homeless children about whom much less is known. This group consists of teenage adolescents, collectively known as street kids. They have many of the same problems as children in homeless families, especially in terms of their cognitive and social development. At the same time, they present different problems. A significant number come from abusive homes and have the personal problems that typify children from such an environment. Younger children in shelters, despite the difficulties of the setting, have the advantage of living within a nuclear family. Street kids do not enjoy this stabilizing influence — they have to face the full brunt of street existence on their own. Many have substance-abuse problems, are victims of sexual and physical violence, and have arrest and jail records stemming from street life.

Estimating the number of homeless is difficult. The obvious method, nightly shelter counts, provides some data, but does not include persons sleeping on the streets and other public places. For homeless street kids, the same problem exists. They present added difficulties since they frequently cycle from natural home, to an institution like a corrections center, then to the streets, and finally home again. For the short period they are on the streets, they are homeless, even if on a situational, not permanent basis.

Estimates about their number vary, but figures from accepted organizations suggest that the magnitude of the problem is significant. In 1985, the American Youth Work Center and the National Network of Runaway and Youth Services placed the total at 500,000.³

Studies emphasize the limited knowledge on this group. This generalization applies to all homeless children, but is even truer for adolescents. They are an extremely mobile group, making it hard to develop contacts for research purposes. Many have an inherent distrust of adults, further complicating the problem of data collection. The difficulties are compounded by definitional issues. Until recently, homeless children and adolescents were grouped with runaways.⁴ Important dimensions of their lives remain unstudied:⁵

1. Health (birth outcomes, nutritional status, immunization status, lead levels, illnesses, access to health care)
2. General development (cognitive and social development, parent-child interaction, child abuse and neglect)
3. Education (school attendance, grade retention, special education, academic performance)

The small amount of existing research focuses primarily on the adolescent homeless in large urban areas. Only one major study examines youth who reside in smaller metropolitan areas. The findings indicate that they face the same risks as those in larger cities.⁶

The New England region has many smaller urban centers. In Maine, Vermont, and New Hampshire, no metropolitan standard area (MSA) has a population larger than 367,000, and two have fewer than 100,000.⁷ Major studies have been conducted in the region's larger cities; for example, the pioneering work of Bassuk and Rubin on homeless families was done in Boston.⁸ Far less is known about the problems of homeless children in New England's smaller urban areas.

This paper is based on the experiences of the Portland, Maine, Homeless Children's Mental Health Project. Portland, a middle-size city with a population of 62,670 in a metropolitan region of 205,700, presents an opportunity to investigate the challenges of adolescent homelessness in a small New England metropolitan area. We first discuss intervention. Next comes a short description of Portland's street kids. Finally, we analyze the service demands in responding to this group.

The Portland Homeless Children's Intervention

In December 1987, the Maine Department of Mental Health and Mental Retardation applied to the National Institute of Mental Health (NIMH) for funds to establish a mental health project for homeless adolescents. Funded in May 1988, along with two other projects in Vermont and the District of Columbia, it provided mental health and substance-abuse counseling, rehabilitation services, and case management to homeless youth in the Greater Portland area.

Drawing on documented needs and community expertise, the grant-writing team identified the major gaps in the system, which are listed in Table 1. The most glaring problem in Portland was the absence of a comprehensive community mental health center, a facility that could serve to coordinate and deliver the complex array of treatment services required by homeless youth. An additional constraint was the lack of data on the characteristics and service needs of this population. Even if a comprehensive program were in place, the limited information would have made it difficult to meet the full range of needs faced by homeless youths. Other problems were limitations of the shelter system, inadequate housing alternatives, few resources to aid youths in developing independent living skills, and a lack of inter-agency collaboration.

The city's Committee on Homeless Adolescents developed a twofold approach to addressing some of these needs. It successfully pursued state funding through the Department of Human Services to establish a low-barrier "safety net" shelter for homeless adolescents. The shelter met the number 1 and 2 needs listed in Table 1.

The city and state successfully joined forces to obtain funds from NIMH. These moneys, along with some from the Maine Office of Alcohol and Drug Abuse Prevention and Bureau of Children with Special Needs, funded the Portland project. This joint effort addressed the treatment, collaboration, and research problems identified in Table 1 (numbers 4, 6, and 10).

In the absence of a multiservice agency, which could have housed the project, it was necessary to hire a full staff. A director was named, employed by the Bureau of Children with Special Needs. The bureau, in turn, contracted with three nonprofit agencies to deliver services. Two therapists, one substance-abuse counselor, and one job rehabilitation specialist were hired. Their role was to function as a multidisciplinary team. Contracts were conditional on participation in the team, coordinated by the project director. A major challenge facing the project would be to foster the interagency collaboration required by this type of organizational design.

At a conceptual level, the intervention was designed to address a persistent obstacle in the delivery of human services. It is well documented that most systems lack integration, producing major gaps in services. The project focused squarely on this dimension, but as important, proposed to go substantially beyond it. It sought not only the coordination of services across agencies, but the design of a process that

Table 1

Gaps in Portland Homeless Adolescent Service System

1. A shortage of shelter beds (25 existing beds for some 200 homeless youth)
2. The inappropriateness or unacceptability of existing shelters for homeless "street" youth (youth's emotional/behavioral problems too severe; youth are "turned off" by structure, rules, parental consent requirements, of these programs)
3. Inadequate housing alternatives for older adolescents
4. Absence of mental health, substance-abuse, or crisis intervention screening, assessment and evaluation, and treatment services deliverable on site to severely emotionally disturbed homeless youth
5. Inadequate short-, medium-, and long-term mental health and substance-abuse inpatient or residential programs
6. Absence of a capacity to treat psychological (depression, anxiety disorders, post-traumatic stress syndrome from abuse, conduct disorder) and substance-abuse comorbidity
7. Absence of any mental health case management or community support services for youth
8. Inaccessibility and unavailability of personnel to ensure that older homeless youth gain appropriate educational, vocational, and independent living skills and employment
9. Lack of interagency and state-local collaboration on program development and delivery of mental health, substance-abuse, and rehabilitation services
10. Extremely limited data about the demographics, characteristics, treatment, and service needs of Portland's homeless youth

would require different staffs to act as a *multidisciplinary* team. In this way, gaps across different realms of knowledge and expertise would be bridged as well.⁹

More specifically, the intervention was designed to answer three major sets of questions, which reflect many of the concerns described at the beginning of this article.

1. What is known about homeless adolescents? What types of problems do they face? Are their problems in Portland, a middle-size city, similar or different from the large metropolitan areas in New England and the United States as a whole?
2. What service delivery challenges did the program face? How did it make contact with the youth? How were its mental health, substance-abuse, and job-training services delivered? What programmatic, staff, legal, and other types of hurdles had to be overcome?
3. What successes did the Project have in fostering interagency collaboration? Was it able to overcome the disciplinary barriers that existed among program staff?

The Homeless Adolescents in Portland

A specific goal of the project was to collect data on the street kids of Portland. As in most cities, facts on their personal problems, home environments, and service needs were virtually nonexistent. Anecdotal information from service providers was available, but provided little systematic guidance on the types of programs and approaches that were needed.

Data Collection

Four different agencies provided data on their adolescent clients. The recording instrument incorporated aspects of intake or screening forms used at the four programs. The original *n* for the study was 807. Removal of duplicate records reduced it by 24 percent to 614. This figure means that for the period of the data collection, one year (July 1, 1988 to June 30, 1989), more than six hundred youths sought services (food, shelter, counseling).

Prevalence of Homelessness

The McKinney Homeless Act states that any person who lacks shelter for a night is homeless.¹⁰ While a starting point, the definition fails to consider the question of the frequency and duration of homeless episodes. Some persons are chronically homeless, that is, living in shelters and on the street for extended periods of time. Others may be homeless for short periods punctuated by stays with friends or relatives or in stable institutional settings.¹¹

Defining adolescent homelessness is even more complicated. First, determination of the extent of situational versus chronic homelessness is necessary. Additionally, youth are on the streets for a variety of reasons. A frequent distinction is made between homeless adolescents and runaways. Some argue the characteristic which differentiates the groups is that homelessness is an involuntary condition. Runaways, in contrast, have made a choice to stay on the street.¹² If this contention is valid, some youths are on the street by choice whereas others have no other alternative. The term "throwaway" is often used to describe the latter individuals — they are on the street because their parents have thrown them out.

As in other cities, youth are on the streets of Portland for reasons other than homelessness. The agencies defined, at intake, just 13 percent as homeless. The number is in the middle of estimates made by other studies, in which figures range from 6 to 34 percent.¹³ Youth were more likely to receive services for short-term personal and family problems (39 percent). Runaways constituted 25 percent of the population. Throwaways were only a small proportion, 3 percent, of the youth served by the agencies.

Portland shows greater differences from other cities in the origin of its street kids. Over a majority, 54 percent, are from outside the metropolitan area. These data contrast with other studies, in which the percentages from within the metropolitan region exceed 75 percent.¹⁴ Situational homelessness may be higher in Portland because more youth are not from the immediate area. They lack ready access to the social supports provided by a home or institutional environment where they may previously have resided.

Despite the small number in Portland who are categorized as homeless, many are situationally homeless, that is, without permanent shelter for short periods. Data show that the youth are frequently on the streets. They have a history of multiple

residential placements, making them at risk of homelessness. Forty-four percent have five or more runaway episodes. Eighty-six percent have been in a shelter, foster care, group home, or residential treatment. Twenty percent have been in two of these settings and 22 percent in three or more.

The Problems of Portland's Street Kids

The major problems faced by Portland's youth mirror those of other adolescents on the streets of other cities. They include educational disabilities, involvement with the criminal justice system, disruptive home environments, substance abuse, and mental illness.

Education. The McKinney Homeless Assistance Act of 1987 states that homeless youth will have access to a "free, appropriate public education." This promise is far from fulfilled. Estimates vary on the number of homeless youths who actually attend school. In one study, reported figures on school enrollment ranged from as few as 43 percent to a high of 70 percent.¹⁵ Even if the latter figure is correct, almost one-third are not receiving formal education. The consequences are obvious. These youths will be at a major competitive disadvantage in the job market, increasing the likelihood that they will remain homeless as they become adults.

Many Portland youth are not attending school. For the cases on which data are available (68%), 35 percent report that they do not go to school. This population also faces other educational hurdles. A significant number have handicapping conditions that affect their ability to perform in school. For the cases with complete information (missing data ranged from 54 to 75 percent), 22 percent have an educational handicap of some type. The most frequent condition is behavioral/emotional problems (49%). Many have special learning dysfunctions (30%). Problems with mental development or maturation account for 17 percent. The large number of missing values indicates the importance of more complete information on the educational needs of this population.

Special education problems are common for homeless adolescents nationwide. Evidence is accumulating that homelessness contributes to educational deficiencies. For homeless youths between five months and eighteen years, mental retardation and language delay rates were significantly higher than for the general population data.¹⁶

Justice System Involvement. Street life results in many confrontations with the criminal justice system. Drug use, prostitution, and beatings are common everyday occurrences. Findings from a survey of homeless adolescents in Hollywood, California, underscore the magnitude of this problem.¹⁷ When asked their main source of income for the past thirty days, 37 percent cited illegal activities, among which were prostitution and drug dealing.

Portland's street youth have a similar history. Sixty-three percent have been charged with a criminal offense at one time or another. One issue, which the data do not resolve, is whether they are habitual offenders. Illegal activities may represent strategies for survival, a way to provide for basic needs. The observed behavior may be situational, not indicative of a generalized pattern of lawbreaking.

The policy questions are complex. How should cities respond to the lawbreaking behavior of homeless adolescents? Portland had a police crackdown on street kids involved in illegal activities in public places, many of a minor variety like verbal obscenities. Putting in jail a youth who acted this way only while homeless may

serve to place him or her one step closer to habitual offender status. A police record makes it more difficult to get a job. The result is that lawbreaking becomes an even greater necessity for survival. A cycle of illegal behavior may begin from which it becomes ever more difficult to escape.

Family Situation. A frequent generalization is that homeless adolescents come from conflictual and abusive family environments. A reason their housing problems persist is that going home is not a viable alternative for many. By definition, homelessness is residential instability. This condition continues, in part, because of the youths' family situations. Limited data are available on this connection, but a study of adolescent psychiatric inpatients reveals a relationship between the number of residential moves and parental separation and caregiver neglect and abuse.¹⁸

A troubled family environment is a common trait of Portland's street youth. Comparisons between the Portland sample and national data show the former group more seriously affected in major categories of family dysfunction.¹⁹ Known or suspected cases include emotional conflict at home (66%), physical abuse by parent figure (37%), neglect by parent figure (31%), and family mental health problems (28%). In the national study, rates for all but one variable, emotional conflict at home (44%), were below 25 percent.

Sexual abuse rates in the Portland data are also higher, depending on the measure, than those reported for the Hollywood youth. In the latter study, 17 percent reported sexual abuse by family member or co-habitant.²⁰ In the Portland survey, 33 percent are cases of sexual abuse, known or suspected. A related measure is physical and sexual abuse by another family member — 21 percent known or suspected cases.

Substance-abuse History. Alcohol abuse is as commonplace among adolescent homeless as it is for adult homeless. Compared to national household samples, homeless adolescents are more likely to try alcohol earlier and say it affects their performance in work and school. They were eight times more liable to have a formal diagnosis of alcohol abuse and thirteen times a dual diagnosis of alcohol and drug abuse.²¹

Portland street youth show a similar level of substance abuse. Fifty-six percent of the adolescents engage in occasional or heavy use of alcohol or other drugs and 53 percent for alcohol specifically. Similarly, in the Hollywood sample, 48 percent met the criteria for diagnosis of either alcohol abuse or dependence.²²

Mental Health. Adult studies show that approximately one third of the homeless have serious mental health problems.²³ Initially, it was thought that the prevalence of psychotic disorders might be lower among youth, because this type of affliction is usually associated with early adulthood or later. However, a study of almost one hundred youths found that 29 percent exhibited four or more psychotic symptoms on a standardized assessment instrument.²⁴ The authors emphasize the limited generalizability of their data and the lack of comparable studies. Nevertheless, the extent of psychotic symptoms suggests that homeless youths are a deeply troubled population. They require extensive mental health evaluation and intensive services targeted to their special needs.

Direct comparisons cannot be made with the Portland data because few of the clients were systematically assessed. However, the available information clearly shows the depth of known or suspected cases of mental health problems among the street

population. Defiant, angry behaviors are common (47%). Depression is a condition for 55 percent. Almost a majority (47%) have suicidal characteristics. An unresolved issue in homeless research, including adults as well, is whether mental health problems are a cause or result of homelessness. The answer is probably both. Also, preexisting conditions are likely to be significantly worsened by the rigors of street life.

Overall, the data indicate that those in the Portland sample face similar problems to street youth throughout the nation, including larger metropolitan areas. For certain personal and family problems, especially child abuse and neglect, their prevalence is even greater for Portland street kids. The small size of Portland and its location in the northeastern corner of the country has not insulated it from adolescent homelessness.

Table 2 provides a summary of the descriptive data, as well as correlations between each problem and homeless status. Positive correlations indicate that homeless — in contrast to runaway/throwaway/crisis — youth are more likely to have a problem. Of the eighteen separate correlations, ten are positive and statistically significant ($p < .05$). The most marked differences exist for school attendance and learning dysfunctions related to mental development and maturation. Most of the correlations are in the weak to moderate level of strength, but the number of systematic differences means that the homeless are the more troubled part of the street population.

Experiences of the Portland Homeless Children's Project

The following discussion focuses on the experiences of the project in trying to meet two of its major goals. First, it was an experiment in providing coordinated services, namely, mental health and substance-abuse treatment and vocational training, to homeless adolescents. Second, it was an investigation into the design of interagency relationships to reduce gaps in the service system.

The Provision of Services

A major objective was to assess and provide crisis intervention and service referral for homeless youths who presented themselves at the shelter. The emphasis was on identification of individuals at immediate risk of suicide and other self-destructive behaviors and on relief of immediate psychosocial distress. As the data on Portland's street youth indicated, many suffer from serious personal and mental health problems.

The objective proved difficult to meet. It assumed several things: that the system's intake point is always, or most appropriately, the shelter, and that youth cooperate at intake. In recognition of these factors, a more informal method of identification, assessment, and triage was implemented. Log data indicate that many of the contacts with clients are quite informal. Only 15 percent involved case management activities, and 81 percent lasted one half hour or less. Through outreach work at various key locations — soup kitchen, drop-in center, streets — staff contacted youth and informally assessed their conditions and needs. Whenever possible, referrals were then made to the appropriate services.

For example, the substance-abuse counselor performed outreach to homeless youth several mornings per week at the breakfast soup kitchen, serving youth and adults. Her services provided an important addition to the morning soup kitchen. The mixture of adults and youth had negative and, at times, volatile effects. She

served at critical times as a stabilizing force. Moreover, morning offers a "window of opportunity" for a counselor to discuss the effects of substance abuse with youth in varying physical and emotional states. The soup kitchen had few professional staff, but many volunteers. The project worker was able to fill an important role, one which would otherwise have been missing altogether.

This type of cooperative arrangement was not anticipated. Some attention in the early stages of program planning focused on colocation, that is, staff located at other agencies and sites besides those of the project agencies. Other research emphasizes the necessity to bring services to the places where the homeless can be found.²⁵ Portland's experience supports this generalization.

A second objective was to get as many youths as possible into mental health treatment, case management, and where necessary, family mediation. The project was

Table 2

Characteristics of Portland's Street Kids

	Percent	Correlation with Homeless Status ^a
Residential Instability		
Five or more runaway episodes	44	-.02
Educational Problems		
Do not attend school	35	.39*
Educational handicap	22	.17*
Specific learning dysfunctions		
Special learning function	30	-.09
Behavioral/emotional	49	.10
Mental development or maturation	17	.25*
Criminal Justice Problems		
Charged with a criminal offense	63	.03
Family Environment Problems		
Emotional conflict at home	66	-.01
Physical abuse by parent figure	37	.10*
Neglect by parent figure	31	.18*
Family mental health problems	28	.002
Parental sexual abuse (known or suspected)	33	.18*
Physical and sexual abuse by another family member (known or suspected)	21	.10*
Substance-abuse Problems		
Occasional or heavy use of alcohol or other drugs	56	.14*
Alcohol (occasional or heavy use)	53	.15*
Mental Health Problems		
Defiant, angry behaviors	47	.08
Depression	55	.11*
Suicidal characteristics	47	.04

a. The correlation coefficient is Pearson's *r*. An asterisk denotes a statistically significant relationship at .05 or less.

most active in the service areas of counseling. A total of 1,465 contacts with youths were made. Eighty-four percent related to counseling.

A much smaller percentage of these contacts involved ongoing psychotherapy. At any given time, staff estimated that approximately ten youths were involved in therapy. The project found that youth want to talk, but accept relatively limited counseling. Unless special efforts are made, a very small number will find their way into therapy. Bridging this gap between counseling and therapy is a service priority for street kids.

As the descriptive data indicated, many youths come from family environments in which conflict and abuse are common. Family mediation was an initial goal of the project. These services were available to the project through a contract negotiated with a Portland area agency with extensive experience providing home-based counseling to families. Although this service was available, it was not used by project staff. Few project youths had sustained contacts with their families. Given the level of physical and sexual abuse many suffer, family contact was often neither appropriate nor advisable. Further, it was found that family mediation was most appropriate at an earlier stage in the development of crisis/runaway/homeless behavior, when children begin to appear out of control and noncompliant with family rules.

New approaches are required that allow youth to achieve more stable living arrangements. This idea is certainly not a new one, having been debated for some time. But the service system has not successfully responded, so the problem continues. Forty-one percent of Portland youth are state wards. Even with this status, Maine has not been able to keep these youths in a positive environment. Until better success in finding stable placement is achieved, kids will remain on the streets of Portland.

The project also provided vocational training. Of the 1,465 client contacts, 7 percent were employment related. Some street youth had a definite interest in securing employment. The project was not particularly successful in providing either vocational training or full-time employment. Very few youths were ready for training or had the background necessary to succeed in securing employment. Agency records revealed that only 19 percent have any history of employment and just 7 percent had actually held a job.

Vocational staff continued to revise expectations for the youths and techniques for assisting them. The assumption was that an individual's progress in mental health or substance-abuse treatment would keep pace with progress toward vocational goals. This expectation was not substantiated. Based on the challenges they encountered, vocational staff concluded that two factors were critical to future success. Intensive and sustained mental health treatment was necessary to help clients obtain and, especially, hold a job. Additionally, job coaching must accompany the therapeutic efforts for street kids to move into stable employment. One clear lesson is that you cannot simply connect them with a job opportunity and expect them to succeed. They have to grapple successfully with the personal difficulties that are important reasons they are unemployed. At the same time, they must learn the skills necessary to complete a successful interview and hold a job. The theory of the project correctly identified the importance of bridging the gap between mental health and vocational services. It was not effective in delivering and coordinating the two activities. The project was unable to improve significantly the employment prospects for most street youth.

Interagency Collaboration

This goal was met in a variety of ways: formal agreements between project agencies, staff locating in other organizations, and informal efforts at cooperation. The principal constraint, only partially overcome, was the lack of collaborative history in the service system. A vital lesson from the project is the significance of understanding the capacity of a system to collaborate before initiating interventions of this type.

A main objective was the creation of a mobile multidisciplinary team, utilizing outreach personnel from several community agencies serving adolescents. The mobile team was established, providing coordinated services to the target population. The extent to which it was truly "multidisciplinary" is questionable. The original grant envisioned a type and level of collaboration among team members that was very difficult to achieve, especially in the short to long term.

Consensus on how the multidisciplinary team should function was hard to achieve. Reasons were largely internal to the project itself. It had a complex management structure, which required staff to answer to "two bosses," their own agency heads and the director of the project. This arrangement, a type of matrix management, allows for flexibility in the assignment of staff resources, but has many points of potential organizational conflict. The question often arises, and did in the project, as to who has responsibility for staff; it was never fully resolved.²⁶

Interagency cooperation was complicated by the inexperience of two agencies. The project focus on homeless youths was new for them. The initial period of program implementation was a learning process of considerable proportions. The agencies had to deal with new clients and work with agencies, inside and outside the project, with whom they had had limited interaction in the past.

The project also tried to link on site with state and community hospital psychiatric services. Case management was the primary means to achieve this connection. The results were not what was expected. The number of actual contacts was relatively small. The log data indicate mental health agencies constituted just 6 percent of the total service contacts. Again, the reasons stem from the particular nature of the homeless adolescent problem itself.

Readily accessible outpatient services were available solely at the Street Program, one of the participating agencies. Outpatient services for children are very limited in Portland — and many other cities as well. They were attainable only through mental health centers or private practitioners in traditional settings. Some adult outpatient facilities do serve adolescents. In most cases, the services do not address the most pressing needs of street kids. They focus on severe and prolonged mental illness rather than sexual abuse or issues related to street life.

Research conducted by the Maine Department of Mental Health and Mental Retardation on children admitted to the state psychiatric hospital shows that the availability of crisis services might have prevented many admissions.²⁷ Crisis interventions performed by project staff, and the daily (Monday through Friday) access by street youth to qualified therapists may have prevented some inpatient admissions. In selected instances, staff assisted clients through hospitalization, either at local facilities or at the state hospital.

Linkage to existing services is not, at this time, the most effective response to the mental health needs of street youths. Instead, a crisis intervention capacity is required first. The number of youths who require more traditional services, especially hospital-

ization, can be substantially reduced if agencies have the ability to respond to their crisis needs.

A rough number of the youths who benefit from crisis services can be derived from the logs. Over the eighteen-month duration of the project, 10 percent or 147 individuals sought help for a personal crisis. Fifty percent (733) met with staff on a spontaneous basis. Although most of these encounters were not the result of personal crises, they dealt with problems that would rapidly escalate if not confronted quickly.

Limited success was achieved in developing agreements with non-project agencies. An obstacle was limited collaboration within the entire service system. An interagency survey, conducted prior to implementation, provides evidence of the barriers. Agencies indicated whether they engaged in fourteen specific types of collaborative behavior. Activities ranged from formal arrangements, for example, cross-agency staffing and funding, through informal ones, such as referrals that can be done over the telephone. No more than 25 percent engaged in any function to a "considerable extent." Table 3 summarizes the data.

The potential difficulties in achieving interagency collaboration were not fully appreciated at the outset of the project. Similar to other examples of social planning for which the scope of the intervention was quite ambitious, insufficient attention was given to the existing capacity of the system.²⁸

Table 3

Forms of Interagency Collaboration

Activity	Activity Occurs to a "Considerable Extent" (percent of agencies) ^a
1. Joint cross-agency assignment, joint use of staff, outstationing, or colocation of functions	25
2. Joint funding, purchase of services, budgeting/ accounting systems, or personnel administration	24
3. Interdisciplinary treatment teams	22
4. Joint diagnosis and evaluation	18
5. Joint training or technical assistance activities on homeless youths	18
6. Joint case conferences or case reviews	18
7. Joint information and referral	17
8. Joint needs assessment, planning, program development, and/or program evaluation	12
9. Joint intake, service, or discharge plan development	12
10. Supervisory or direct-care peer support networks	12
11. Joint monitoring and follow-up	11
12. Joint public education on issues relating to homeless children	6
13. Promoting youth peer support and/or peer counseling programs	0
14. Joint data systems, MIS, or record keeping on homeless children	0

a. The questions are drawn from the *Maine Child and Adolescent Service System Profile* developed by coauthor James Harrod. Data were collected from twenty agencies in March 1989. The staff of the project compiled a list of the agencies which, in their opinion, played major or supporting service roles for homeless youths. Some were shelters, while others provided basic services such as substance-abuse and medical treatment. Correctional agencies at the city and state level were also included. This type of sampling design is known as a key informant survey.

The project allocated staff resources for the purposes of collaboration among the participating agencies. None were provided for possible areas of interaction between the project agencies and other organizations within the system. A basic proposition in

interorganizational behavior is resource dependence. It states that organizations collaborate in order to gain resources. Without resources or some equally compelling reason, collaboration is resisted.²⁹ Rather than specifically targeting resources for systemwide collaboration, the designers of the project assumed that staff could network to produce the desired levels of coordination. Some staff did perform this function, but not to the extent that marked gains were made in the involvement of non-project agencies in service delivery. Throughout the course of the intervention, other agencies viewed project staff as additions to existing activities. To the other agencies it was more a case of resource supplementation than creating a condition of dependence. A greater level of resource dependence was necessary for sustained collaboration to occur.

A significant amount of resources was required to produce marked changes in interorganizational relationships. The reason was the emergent nature of the system. Homeless adolescents were not a new problem in Portland. Yet concerted systemwide efforts to address it was a recent development. Goals and alternative strategies were just being formulated. Agencies were only beginning to explore interorganizational strategies in a planned and coordinated sense. The idea of life cycle is an important explanation of how organizations change and develop.³⁰ The planners of the project failed to appreciate that the system was early in its life cycle, at an emergent stage. Their concept of collaboration was more appropriate for a system with a history of agency dependence on each other.

A subgroup of the homeless, street kids, has only lately received attention. Portland, Maine, adolescents who are homeless, runaways, throwaways, or youths in crisis face a number of problems. Data collected on these youths showed that a relatively small number are actually homeless. This group, however, are the most troubled part of the population. They have greater educational, family, substance-abuse, and mental health problems than other kids on the street.

A question was whether homeless youth in Portland were similar to those in other large urban areas of New England and the United States. The similarities were marked in terms of the prevalence of homelessness and their personal and social problems. Portland is not isolated from this dimension of the homeless problem. If this pattern is evident throughout New England, policy initiatives targeted for homeless adolescents must not assume that it is a problem only of the big cities.

Portland does differ in one major way from larger cities. The majority of street kids are from outside the metropolitan area. The service implications are major. Youths may have more difficulty in getting their service needs met in Portland. They do not have ready geographic access to their previous residences, where critical services and supports may be available. Whether other New England cities similar to Portland have this pattern of adolescent migration must be answered.

The project had mixed success in meeting its goals. Street kids are not an easy group to engage in service delivery. Agencies need a lot of time to work on multidisciplinary approaches. Collaboration within a service system, if resources are not available for this purpose, is hard to achieve. In this regard, we do not know whether Portland is a typical, middle-size New England city. However, the depth of problems faced by its street kids and the difficulty the project had in responding to their needs underscores the importance of new policy initiatives. Adolescents develop rapidly into adults. We do not have much time if this generation of street kids is to become something other than tomorrow's homeless adults. ❧

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Triangulation in Monument Square

S.B.

Tonight I sit here in my kitchen, ready to begin this story. It's one o'clock in the morning, and there is a thunderstorm going on. My poor cat slipped out of her flea collar last night, and got loose in the neighborhood. Tonight she will have to sleep under a car somewhere.

I am waiting for my cup of Green Mountain coffee to finish brewing, and I keep looking at the painting of a sailor that my friend Sarah gave me. It looks down at me and appears to be a combination of Brutus and Popeye. It could be a child of triangulation between Olive Oyl and her two cartoon friends. Someday I'll figure out whether this painting belongs here at all.

A little over a year ago I was in another state, living in a two-man pup tent. It was right next to the power lines and railroad tracks. On the occasion of a thunderstorm it was pure shit. I'd usually have to sit there and bail out the tent. I'd be soaked, and scared about getting hit by lightning. After it was over, I'd go out to the railroad tracks and shout to God what kind of parents I had to bear me into this nightmare. Fortunately, there were few storms during the two and a half months I lived there.

I was living in the tent because I had run out of friends to live with, and I wanted to spend my money on cocaine and beer for one-night parties for myself. The last home I had was in a crack house, where I went insane with the drugs, the inhabitants, and the clientele.

Finally, the summer was ending, and I knew it was time not only to end my camping lifestyle, but my twenty-five years of drinking and drugging, which had led to this unmerciful bottom in my life. I talked it over seriously with my parents, the last two people I had in my life, and decided to move to Portland, Maine.

The only way I could accomplish this was to save some money. First, I tried getting locked up in a detox. That only lasted four days, and I drank as soon as I got out. Then I tried working for a friend who was a drug dealer, fixing his limo, but I only used the money for alcohol and cocaine.

In the detox, I had learned from heroin addicts about another detox, where they locked you up for ten days minimum in a state prison. So I tried this, and stayed twenty-three days. I had my money saved and had stopped the desire to use drugs.

Then it was back to the little green prison of the tent to prepare to leave for Maine. On that last day I had planned a schedule to get the money out of the bank,

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buy clothes, get a ride to Boston, and get to Portland by bus. I knew I also had to get into a homeless shelter by five P.M., so timing was important. That last night I couldn't sleep, and paced the railroad tracks, taking a mental picture of them, which I still haven't forgotten.

Departure day happens, I say a quick goodbye to my parents in Boston, and ride a Greyhound up to Portland, cursing the state I had just left. There wasn't much of a mind to curse with. I got to Portland with a half hour to get to the shelter. As in the past, having good luck asking people for help, I had gotten somebody to ride a bus with me to a downtown terminal, where I connected with a bus to the shelter.

At the shelter I balked when asked for my license, because it had a warrant on it. I really wanted to leave the past and all of its shame behind me. I remember my mind's being pretty fried during this process. Over the next few days, I found myself living the life of the homeless. I walked the streets, and once went into a bar instead of looking for work.

I checked the bulletin board at the shelter, which announced NA meetings, a Prolixin clinic for the mentally ill, employment counseling, GED preparation. Also, there was confidential AIDS testing. Yes, I belonged in all these programs. I was in that class of people who had hit the bottom, and I felt it.

After a few days I made contact with some people, and arranged to stay with them by simply getting drunk and passing out on their couch. Again, I was lucky being helped out by people I didn't know. For three weeks I stayed there, and finally, after one of many drunken parties and brawls, I left for my own apartment. (Having recently gotten a job, I had some money, and found an apartment, and moved in within an hour.) Moving in was easy; all I had was a gym bag and a six-pack for company.

So, in three weeks I had a job, an apartment, and some drinking friends I had to avoid because they were too violent, and a refrigerator for my beer. I needed it to fuel me for work. There was one disturbing fact; I had just learned that my mother and brother had cancer. I postponed thinking about this news and built up my strength by isolating myself, working seventy hours a week, and drinking heavily. I *thought* this was building my strength.

This went on until my birthday. It was then that I sat down after a good day at work. I had had the opportunity to teach a bright young apprentice some tricks of the trade, which I had become good at despite my drinking. It was rare that I had a good day at work.

Suddenly, all these emotions, the good and the bad, caught up with me. I sat down and cried for hours over my family and my life. I was very lonely. I became very sick then, mentally, physically, and spiritually. I knew this was from alcohol. I lasted two weeks on the job, and burned out after working seventy-two hours in five and a half days.

I quit my job, went back, and screwed up again, drinking on the job; I then went back home on a \$1,200 drinking binge. My goal in the binge was to kill myself, but I couldn't.

I went back to Portland and quit my job again. Any ideas of getting stronger were gone now. I stayed home and debated seeking help for what I was now considering alcoholism. I couldn't leave the house for days, thinking God was going to strike me down for my drinking. I finally went to an AA meeting drunk, then approached some

friends up the street for some help. The next day I went into the program at the Salvation Army. I told them I had been sick for a few weeks and needed counseling.

Although I stayed at the Army for a few weeks, the experience was not good. Group living and its restrictions bothered me. It didn't work. I was thrown out on the street on an eight degree day in January, and for the first time in my life I was grateful I was sober.

I went to see somebody at Community Alcoholism Services and got to talk to another recovering alcoholic. This was a great amount of relief to me. Since then I've learned just how much it can help to talk to another recovering alcoholic. I found myself another place to live, a room this time, and again, began the struggle to piece my mind together. I sat for hours next to an AA meeting book, holding on to what little peace of mind I had left.

This house was supposed to be alcohol-free. Not so, as the house manager was drinking himself. In three weeks' time, a familiar period of time, I threw away two months' sobriety, by having the so-called manager buy me some beer. After I passed out, I woke up and went out and searched for some help, any kind of help. I was filled with despair. Nothing could be done. I returned feeling angry, and abused by the world, full of self-pity and loathing. I took a razor knife and cut open my arm. At last I could feel myself again. The blood told me I was a living person. I used my anger to cup deeper into the vein, but couldn't. I knew at this point that I wasn't going to die, and would somehow ask for help again the next day.

The suicide attempt got me into Jackson Brook Institute for the next twelve days. For the first time in years I felt that I was being cared for. I left feeling like a new person; I actually liked myself.

I was placed in a transition house with a reputation for bad conditions, and they were bad. For a while I made it, despite everything. But I wasn't ready for sobriety yet. On the night that I picked up my thirty-day chip, I turned it all over with a 4,000 milligram overdose of Thorazine.

What happened next was that I asked for help again. An ER nurse later told me that I'd been comatose and couldn't be revived. I remember a doctor telling nurses to hook me up to a heart machine quickly, because I was "going." This was six months ago, and I'm grateful to be alive.

I was discharged from the transition home for unclear reasons, and once again became homeless. That evening I was standing in front of the house where I'd been on my last drunk, thinking about going in and asking for a couch to sleep on. Right at that moment, the person who had discharged me from the transition house that morning came along and asked me caringly how I was doing. My faith in people was restored. I avoided drink and found another place to stay that night.

I went into another transition home and stayed for three and a half months. I stayed sober. It was still group living, and hard to take, but I grew in sobriety. Unfortunately, I became homeless again and began deteriorating in the last six weeks. One thing though, I got approved for Social Security Disability, and have been able to get my own apartment, a car, and furniture. I have a chance now, and do feel happy occasionally.

I have written this story, not only to share with others, but to help myself. I returned to drinking after four months of being sober. I can't stop and am scared, and will be sick and desperate soon. This is a hard disease, and I know I can't be helped until I want to help myself. ☹️

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Homeless Children Having Children

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Homeless teenagers who have babies pose a significant population of concern for those in health and human services. This article explores demographic, structural, and economic changes for homeless young and single-parent families. It proposes that their homelessness is due to these barriers and the problems that result. Case studies illustrate the process of troubled teens becoming homeless women with babies. Policy recommendations for assisting these youngsters are offered.

While the term “homelessness” engenders stereotypes of urban bag ladies and skid row bums, there is another group of homeless that is more invisible and vulnerable — homeless teenagers who are having babies. These sexually active teenage “children” have babies and experience all the challenges of adulthood without the developmental, financial, educational, or social advantages of that role. As a result, their ability to fulfill the roles of successful parent and employee are significantly jeopardized. Their personal problems are exacerbated by their youth, social, educational, and economic obstacles, and dysfunctional homes. Because these teenagers are considered neither child nor adult, they struggle without the privileges of either status but with the burden of both, as children developmentally who are carrying out adult responsibilities.

The teenagers portrayed in this article endured social and personal problems for some time before they became homeless. In every case, they demonstrated remarkable strength in handling adverse personal and social situations. In each case, had social intervention been accessible to them, their homelessness would not have resulted.

Yet these children having children consistently found themselves falling through the cracks in the social service delivery system. Assistance typically provided to children was not available to the teens who were older than fifteen. Since they have not been emancipated (to be emancipated requires that their parents sign forms to indicate the child is “independent”), the homeless teens did not qualify for many forms of adult financial assistance.

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I supply the number of homeless children and families, identify problems for young and single-parent families, and discuss how these problems contribute to homelessness. Case studies that illustrate the process from being a teen with troubles to being homeless with a baby are included. I conclude with policy recommendations for assisting this homeless population.

Data Sources

The case studies presented here were obtained in two concurrent studies. One profiled homeless students for the New Hampshire State Department of Education,¹ while the other was part of a University of New Hampshire sociophotography course, "Being Homeless Through the Eyes of a Child." These studies afforded detailed interviews with homeless children, along with photographic illustration.

In both projects, the homeless children were from New Hampshire. While most of them lived in cities, the cities were small (50,000 or less). All the teenage subjects had middle- or lower-middle-class backgrounds and had lived in homes their parents had owned or rented for extended periods of time. None had been homeless until the past year or two. All of them resented being called homeless, preferring to see themselves as living independently. The subjects were interviewed in their own environment about the cause of their homelessness and its social and psychological impact on their lives.

Homeless Families and Children

Homeless families and children, who were 10 percent of the homeless population in 1980, today constitute at least a third of the national homeless population.² Families are the fastest growing subgroup of the homeless.³ In some cities, more than half the homeless are families.⁴

The majority of homeless family members are children who are spending their formative years on the streets without the basic resources necessary for healthy development. Most of these children are five years old or younger.⁵ More than 100,000 children are homeless on any given night.⁶ A U.S. Department of Education report, based on state estimates, asserts that annually there are 220,000 homeless school-age children. But the National Coalition for the Homeless estimates at least twice as high a figure of homeless children.⁷

The National Academy of Sciences⁸ has termed the growing phenomenon of homeless children as "nothing short of a national disgrace that must be treated with the urgency such a situation demands." Without elimination of homelessness and the resultant health risks and concomitant problems, the desperate plight of homeless children, the suffering, and the needless deaths of homeless Americans will continue.

Challenges for Young Families

Both single parents and young two-parent families are in "extraordinary trouble" — trouble that can lead to their becoming homeless. Since the early 1970s, young families have suffered a frightening cycle of limiting earnings, decreasing numbers of people marrying, a near doubling of birth rates among unmarried women, increasing numbers

of single-parent families, falling incomes (down 25 percent from 1973), and skyrocketing poverty rates.⁹

Young workers, of whom there are 20 million non-college-bound sixteen- to twenty-four-year-olds, suffer extraordinarily high unemployment rates: 6.8 percent for whites and 32.4 percent for blacks. Their actual income is and has been in steep decline for more than a decade. Males aged twenty to twenty-four earn fully one-quarter less than the identical age group did thirteen years earlier, earning \$9,027 in 1986.

Incomes of families headed by twenty-five-to-thirty-four-year-olds rose faster than others' between the late 1940s and early 1970s, but since the early 1970s, have fallen farther behind other age groups. Much of this decline is due to plummeting earnings of high school graduates; it has put home ownership beyond the reach of many.¹⁰

Young families have borne the weight of this economic dislocation. The real median income of families headed by someone under twenty-four fell 27 percent from 1973 to 1986. Their ability to purchase homes also declined sharply, with ownership among married household heads under age twenty-five falling from 39 percent to 29 percent between 1973 and 1986.¹¹

Between 1974 and 1986, the proportion of married twenty-to-twenty-four-year-olds living with their spouses plummeted by half, from 39 percent to 21 percent. The percentage of males of that age able to support a family of three above the poverty level dropped by a quarter, from 58 percent in 1973 to 24 percent in 1986. The rate of decline among blacks in the same age group was more than twice as great — a full 55 percent.¹² The result is an increase of single parents, who are typically female.

Single mothers find themselves systematically prohibited from earning adequate incomes. While women bear children and are expected to care for them, they earn 60 percent of what their male counterparts earn in the workplace.¹³ One of two female householders earns less than 50 percent of the median wage.¹⁴ The pay gap between men and women has not improved for women; in 1986, women made 64 cents to a man's dollar — exactly the same gap working women faced in 1955. By 1988, women with a college diploma were making 59 cents to their male counterparts' dollar.¹⁵ Even if they are able to find an appropriate job, it takes 1.7 wage earners to reach what the government defines as "middle income."¹⁶ Furthermore, there is no nationally subsidized quality day care program, so mothers are constantly struggling with maintaining a balance between work and child care.¹⁷

One parent must work forty hours a week at \$5.40 per hour for fifty-two weeks a year in order to earn \$11,200, the current poverty line for a family of two adults and two children.¹⁸ It is virtually impossible to pay for quality child care, adequate housing, and meet the rising costs of food, clothing, and transportation. Many of these jobs have no benefits, thus health care becomes an additional burden for these families. Given the extraordinary costs that young and single parents must confront, it is no surprise that many cannot meet the debts and become homeless.

Poor Young Families Can Become Homeless Families

Homelessness does not typically occur as a sudden single "event"; rather, it is the result of a variety of personal and structural factors that go awry over time.¹⁹ A young family's financial and child care struggles, coupled with a depressed economy that has few available jobs for the unskilled and uneducated, puts them at high risk

for becoming homeless. This is especially true for those who do not have a strong social network to help them.²⁰

According to the Children's Defense Fund,²¹ a typical poor family with children spends 70 percent of its income for housing, leaving them with \$3.49 a day for all other expenses. Between 1970 and 1989, the proportion of children living in doubled-up households rose by 42 percent. Federal funds for low-income housing were cut by more than 80 percent during the 1980s, while the number of poor households in need of assistance rose dramatically. Only about one in four poor households now receives any housing assistance at all.

Only 6.3 percent of all single-parent families were able to afford payments for their own home in 1987, down more than half from 14 percent in 1973. As a result, the number of young, single-parent renter households nearly doubled. It is estimated that these young families would have had to pay 81.1 percent of their total income to afford decent rental housing in 1987, up from 46 percent in 1974. In 1986, 32.6 of every 100 families headed by a person under twenty-five was poor, triple the rate for all American families in 1986 and more than double that of 1976.²²

With financial problems come personal problems. Sometimes personal problems may cause financial problems, but more often financial problems beget an avalanche of personal disaster. Young families do not have the equipment to survive such calamity. As Woody Guthrie left his wife and children during the Depression when he could no longer support them, countless families break apart today because of financial and personal duress. This leaves young women alone to care for their children as best they can.

Hundreds of thousands of new "families" are begun by single teenage girls each year.²³ For these new mothers the responsibilities of child care, combined with limited educational and economic mobility, virtually assure that a state of poverty will result. In addition, conditions that contribute to poverty among both men and married women — lack of education, inadequate job skills, poor health, racism, and lack of job opportunities — are exacerbated for single women.²⁴

Which families become homeless most frequently? At the 1989 national conference on Health Care for Homeless Mothers, Children, and Youth, it was found that the majority of homeless families consist of single women and their children. Mothers of homeless families tend to be young, ranging from fourteen to fifty, with a median age of twenty-nine. Over half gave birth to their first child by age twenty, and one-fourth became mothers by age seventeen. The average size of the families was two to three children.

Homeless Teenagers Who Have Babies

The homeless population of most concern here is that of children having children. For a teen, to be pregnant or parenting is a crisis. To be homeless is a crisis. When these problems occur together, they exacerbate each other. Both conditions increase the risk of a poor birth outcome. While pregnancy and parenthood heighten a teen's need for health care and other services, homelessness reduces the ability to gain access to these services. For teens who have not completed high school, have poor employment skills, and are not socially, psychologically, or financially "mature adults," parenthood provides another obstacle for their achievements.

The Shelter Committee of the Illinois Caucus on Teenage Pregnancy identified several subgroups of homeless pregnant girls.

- Runaways and throwaways who have become pregnant since leaving home; some may have run from foster care. These young people are often reluctant to seek help from public agencies due to their concern that custody of the child may be taken away.
- Teens from relatively stable homes who are forced out because of their pregnancy, or might have moved out to be with a boyfriend and then been deserted.
- Teens whose already troubled families cannot bear the additional stress or expense of another child. Many of these teens and babies move from family member to friends and often do not come into contact with any service system.

The National Health Care for the Homeless Project found that pregnancy rates sharply distinguished homeless girls from girls nationally; 14 percent of homeless girls thirteen to fifteen became pregnant compared to 1 percent for "housed" girls of the same age; for girls sixteen to nineteen, the pregnancy rate difference is 31 percent for homeless and 9 percent for nonhomeless girls, respectively.²⁵ Therefore, homelessness can be seen as a contributing factor to teen pregnancy. Once homeless with children, a teenager confronts escalating problems.

Sexuality, Pregnancy, and Homelessness

In our studies, teenagers who become homeless were found to have had chronically troubled family lives. The most commonly cited problem leading to teen homelessness in the New Hampshire studies was the ongoing parent-teen conflict, which was exacerbated by the parents' financial problems. Because of these problems, the relationship between parent and child became so strained that the teenager often felt unloved. Parents who attempted to use coercive physical or verbal means to control the teen's behavior often lacked the skill to convey their concern for their child. As a result, the teen became increasingly marginal to the home, seeking outside sources of support. When their external sources of support were deemed unacceptable by the parents, the teens and parents became further alienated. One problem fed on another until every incident became volatile and the teens were forced from the home.

The girls who became homeless were often looking for somebody, anybody, who might give them love and protection. In the study of school-aged children, it was found that many estranged teenage homeless girls looked for a Prince Charming who would sweep them up and whisk them away from their misery. The girls typically became sexually active as a way to maintain relationships that they hoped would keep them from being out on the streets alone.²⁶

The four categories of teens who were forced out of the home to become homeless in the New Hampshire Case Profiles of Homeless Children study were (a) children who were kicked out of the house and not allowed to return; (b) children who were pushed out of the house and probably could return if either the parent or

child would modify their behavior (but neither will); (c) children who were either pushed out or left who would like to return, but cannot go back; and (d) children who left the house voluntarily and refuse to return.²⁷

In all four categories, had the family received appropriate intervention, the teenagers may not have become homeless. Once homeless, the risk of pregnancy for girls skyrockets. Once pregnant, the ability of the girl to provide economically for herself diminishes.

The progression of homelessness begins with family conflict that fragments the family members. Once alienated teens are pushed out of the household and forced to "live independently," they find themselves in need of someone who can care for them. In their search for physical and emotional security, they may find themselves sexually active, with pregnancy a likely outcome. Babies pose significant pressures on any family, and are especially problematic for young people, who in many ways are still children themselves. Homeless teens do not have access to the resources that would enable those who are more socially and financially secure to get through this time with fewer problems. Even relatively secure male-female relationships can become strained when babies come; pressures are compounded when social, housing, educational, and financial strains are added. If a girl doesn't start out as a single mother, she may find herself one when all the stressors prove too much for the couple relationship.

Case Studies

The following steps illustrate young women who are in various stages of this homeless progression.

Family Conflict, Alienation, Homelessness

Kristen's parents were divorced when she was eleven, whereupon she and her mother lived satisfactorily together. Once her mother remarried, life became more difficult for Kristen. She and her mother fought all the time, and Kristen felt that nothing she did was okay. "They seemed to think I was so bad, but I really didn't do much of anything." The conflict between them escalated over the years. Staying with her biological father was not a realistic option for Kristen, because she did not approve of his new wife, "who is just a couple years older than me."

Kristen did her best to stay away from home by holding down two part-time jobs and attending high school. Eventually, she decided she could not stand it anymore and moved in with a boyfriend. That situation "didn't work too well." She has moved from living with one boyfriend to another, in hopes that one will marry her and make her life better. She has not applied for any financial aid from social service agencies, because "all the kids like me tell me that I won't qualify. They tell me the workers ask all kinds of questions and then don't give you nothing. I'm better off trying to handle things myself."

Maybe . . . If I Sleep with Him . . .

Elizabeth became homeless because her father disapproved of her friends and lifestyle and threw her possessions into the street. He put all her clothes and personal belongings in a pile on the front lawn and set them on fire. With only the

clothes on her back, she was told to "get the hell out of here, and don't you ever come back." People were good about giving her their extra clothes, but no one gave her underwear or shoes that fit. No one even thought to ask what she needed most, so Elizabeth was forced to ask the school counselor (whom she did not know) if there was any way she could get an extra set of underwear. Her school counselor contacted thirty-five social service organizations to find a place for her, but for a variety of reasons, Elizabeth did not qualify for assistance. Therefore, taking care of herself is "the best option I've got."

In the past six months, she has lived in eight different places. She has lived in houses and trailers, with friends and alone. She lives with some friends for a couple of weeks, then has to find a new place. Often these friends are males. The longest she lived with one boyfriend was a month. Elizabeth currently lives with another boyfriend, his parents, and his two siblings. She has lived there for two weeks. She is sexually active with him and thinks he treats her "bad," but she tolerates him because she has nowhere else to go. She uses no contraception and depends on her boyfriend to do what is right. "I'm very embarrassed about my situation and I always try to hide it from the other kids. It's really not my fault, but I feel guilty." While staying with him is "bad," she has no place else to go.

If We Love Each Other . . .

Heidi and Joe met in the fall of 1989 at a Florida high school. By Halloween they were serious about each other. Heidi was living with her mother and stepfather in a home where there was more bickering than love. Joe was living with his mother and her abusive boyfriend, whose loud arguments often turned physical when they were drunk. And that was most of the time, he said.

Both teenagers wanted out of these problematic families as much as they wanted to be together. Joe called his father in New Hampshire and told him about the problems he and Heidi were experiencing in Florida. His father agreed to let him move north, and an uncle paid his plane fare. Heidi took a less direct route to New Hampshire. She bounced around a couple of places in Florida after she moved out of her mother's house. Then she moved to New York to live with her grandparents. This was a calculated move because no one in her family wanted her to go to New Hampshire to be with Joe. She wasn't there a month when Joe drove there to take her to New Hampshire. His parents had agreed she could live with them. For the first time, things appeared to be falling into place. They thought they would finally live in what was a more stable home where they could finish their schoolwork and earn high school diplomas.

Heidi got pregnant. "After that, things got real uncomfortable. We knew the rule about no sex in the house. We goofed. But we never thought it would come to this," Heidi asserted. She was told she had to move. A teacher at the high school, who taught classes for pregnant teens, knew of her troubles and contacted the homeless shelter. This solution solved her housing problem, but posed severe relationship problems. Joe was put in a situation: "I felt torn. What do I do? Go with the woman I loved (and become homeless) or stay with the family I loved? What family do I go with?"

They lived in the shelter from March through high school graduation in June. Heidi, the more accomplished of the two in the classroom, is generally an A student.

She was given an outstanding achievement award for her work in her Law II class. Joe is an average student, although he said he enjoyed school much more now than he did when troubles at home dropped education off his list of priorities. "I love [school] now," he stated.

At the shelter they sleep in bunk beds, and their expenses are covered by city welfare, food stamps, and two jobs that must be part time to fit around their full-time school days. Medicaid pays the medical bills. They have \$400 in the bank. Without a car, they are dependent either on their own two feet to get them around or on the generosity of friends for a lift. They always offer to help pay for gas.

Both Joe and Heidi said they feel far older than their age. They seldom have time to be "kids," but did make plans to go to the high school prom. Heidi found a dress at a used clothing store for \$50, and Joe bought the \$20 prom tickets. Instead of going out to eat before the prom, they are eating at the shelter. "I would have liked all the extra stuff for her," Joe stated. "Fancy restaurant, limo, and all the fun stuff that a lot of my friends are doing. But it's too expensive."

After graduation, they planned to move back to Florida. They are going to Heidi's mother's house; this time Heidi is confident things will be better. "This baby's changed a lot in my family. It's brought my family closer together." While Heidi goes to live with her mother, Joe will fly to Michigan to begin a five-year hitch in the navy. He chose the service because of the instant paycheck it will provide his young family and for the credits he will receive toward college tuition. After Joe is out of boot camp, after the baby is born, after he's assigned to a base, Heidi will join him. "We're banking on the fact that the navy will be the start of the end of our struggle," Joe stated.

Both teenagers get angry at the people in their school who seem to take money for granted, and for those who characterize people on welfare as shiftless and exploitative. "There are people who don't care and who don't want to try," they admit. "But then there's people like us. We'd do anything to get out of [the homeless shelter]," according to Joe. "People should open their eyes and see that the homeless aren't just the people you see on the streets and in doorways." "There are a lot of people out there with a lot of different reasons for being without a home," said Heidi.

Homeless Once, Twice — What Next?

Randi's father molested her when she turned twelve. "I believe he was devastated because he lost a good job and all his money for some scam his friend talked him into. He was never the same after that. Our family was happy and good. Then this happened. He got more unhappy, and he started hitting on me. My mom never believed [he was sexually abusing me]." But the school counselor did, and Randi was put into a group home where "I didn't want to be at all. The kinds of stuff they made you do there was ridiculous. So I started acting up to get what I wanted. I wasn't gonna get anything any other way. Finally, they kicked my ass out, said they'd had enough of me, that they didn't care where I went." The group home packed her bags and put her out at five one night. "I was free! But I had nowhere to go, and bummed around here and there for a while.

"Then Billy and I got together. He worked some and I had a [Social Security] check, and we got an apartment together. I quit school and we partied. Then I got pregnant. Billy stayed around for a while; he was good to me. But he lost his job and couldn't find another. He'd fix supper for me when I came home from work 'cause

I'd be too tired. I was a clerk and on my feet all day, pregnant. Then baby came, and I couldn't work and keep the baby too. We had no money, so Billy left.

"After he left, I tried to keep my place by taking in a girlfriend as a roommate. But I came home one day and found she left, and took most of my things. I had no money and no [house furnishings] anymore, so I had to move back in with my parents.

"My dad made it real clear that I could stay if I would be 'available' for him. He tried to put the moves on me, and 'cause I wouldn't, he threw me down the stairs. My mom heard us fall and pulled his hands off my neck in time. Yeah, I could go live there, but who in the hell would want to? That's why I am here at the shelter. I am blacklisted in this city because I couldn't pay my rent back when Billy left me. No landlord will rent to me. I got no savings for a deposit, and I don't have enough schooling to get me a good job. [Social services] are seeing if they can get me adult aid, but my dad won't emancipate me [so I cannot qualify for assistance]. I am trying so hard to be a good mother to my baby, but I need help. I can only stay at the shelter two more weeks. What then for my baby and me? You tell me."

Recommendations for Interventions

The teen families portrayed in this article did not have to become homeless. There were logical points for intervention, as follows:

Family Conflict Resolution

The conflict teens experienced with their parents is not dissimilar to that experienced by countless other teens. However, for those who became homeless, there appeared to be no negotiation, no mediation, only unyielding boundaries set by both parent and teen. The demands of each became increasingly unacceptable to the other, which resulted in the teens being kicked out, pushed out, or leaving voluntarily. The families did not have the personal skills to salvage the parent-child relationship, nor were outside agents typically sought to assist them.

Once a teen is out of the home, it is difficult for both parent and child to find face-saving ways to bring the teen back into the family. Neither party can back down without admitting fault. There is also the fear that a teen who asks to come home would be rejected again.

I've had enough. I want to go home. But they don't want me back, and I don't know how to make them want me. I've picked up the phone a hundred times to call them; sometimes I do, and then I hear his voice. I can't talk. My throat closes up, and I hang the receiver up.

Therefore, conflict resolution is important to preventing teen homelessness in the first place, but it is also an important vehicle for the reconciliation of homeless teens and their families. Family conflict resolution training should become a regular part of high school instruction, so that students have skills with which to manage conflict with their parents or their partners.

Providing Assistance

Teens who do not live with their parents often do not qualify for financial assistance when they are under eighteen and unemancipated. Yet parents may refuse to provide care and protection to the teens, or the teens may refuse to accept the condi-

tions of their offer. This leaves them in a Catch-22 situation in which they cannot obtain social service benefits as either child or adult. The result in these studies was that the teens typically have not received aid at all.

Homeless shelters may find themselves in a legal bind by not being able to take in underage teens. Yet shelters realize the bind put on teens who have nowhere else to go. The study found a paucity of places that an independent living teen, who was not emancipated, who had no financial aid or significant source of regular income, could stay. Such teens were left going from person to person, place to place, making do as best they could. They reported experiencing a variety of organizational obstacles that prohibited them from obtaining shelter, food, and other basic necessities.

Sometimes assistance may be available, but the teens perceived that the social service system would not be able to help them. Whether they are given clothes, services, aid, or shelter, the teens reported that they were not asked what they needed or wanted, that those who were in the position to give made assumptions about what was necessary. If the teens had been more actively involved in their care-providing process, they probably would have been more adequately served, with greater satisfaction from the services received. The teens reported hearing from other teens that agencies had lots of red tape without being able to help them. As a result, all too often they didn't even apply for aid.

Community resource information for assisting families and teens in conflict should be made available at a variety of readily accessible locations, at a cost that is not prohibitive for teens and poor families. The system needs to find ways to be welcoming, instead of discouraging, for this high-risk population.

Alternative Arrangement Provisions

Some homeless teens could go back home if both parent and teen adhered to guidelines generated from a conflict resolution effort. However, many teens become homeless because it is safer for them to be on the streets than in their own home. Teens who are the victims of physical and sexual abuse may find it safer to brave the uncertainties of "independent living" than enduring the known certainty of abuse. Social policies must reflect this reality and make alternative living provisions for such teens.

For teens who are found to be living "independently" yet are not emancipated, there needs to be some sort of official resolution to this situation. Efforts should be made to bring the parent and teen together when possible, but when it is not in the best interests of the teen to do so, a policy for alternative living must come into effect. If the parents feel that they do not wish to be responsible for the child, their rights could be terminated, allowing the state to approve aid to assist the teen in meeting basic necessities. In this way, someone would be legally responsible for seeing that the teen's basic needs are met, and help keep teens from falling through the cracks of the human service system by assuring they meet assistance criteria.

When teens ask for help, help should be provided. Failing to provide it will increase their problems and the likelihood that they will require future assistance; increase the severity of their subsequent problems; and decrease their faith that the social structure will assist them. Deterioration of faith in the system fosters decreased respect for, and adherence to, the social order.

Schools: Sex Education and Career Development

The teenagers studied were generally sexually active, many with multiple partners. The basic fundamentals for building solid, committed relationships were not always present as the teens searched for intimacy, comfort, and momentary pleasure that could lead to a lasting relationship. Sometimes the teens conveyed a lack of information about conception and contraception. Sexual education, availability of contraceptive devices, and information and support for the establishment of healthy relationships appear essential for high-risk teens.

The acceptance of traditional female role prescriptions keeps girls locked in their own repression. The illusion that "babies will make everything better" has contributed to their sexual involvement with inappropriate partners. Homeless girls desire someone who will love them, who cannot go away, and this person may be a baby. Many homeless girls reported wanting to be good mothers so their babies would not grow up to repeat their mother's unfortunate experiences. When asked what they would like in the future, most of the homeless girls reported wanting to be married (with a husband who would take care of them), or jobs in a day care center. Home and family take precedence over career-oriented goals that would help the teenage girls become self-sufficient. As illustrated in the case of Heidi, many homeless girls do very well academically in high school. They could go on to college, given the right support. However, their personal problems and homelessness result in their putting academic and career achievement on the back burner in order to address their immediate survival needs. Once poor, homeless, and with children, teenage girls with aspirations may find themselves poor, entrenched adults with limited opportunities for college or career growth.

Homelessness in teens and its subsequent personal and social problems is preventable. Social service, education, and family policies must address the needs of teenagers to prevent countless numbers from being "homeless children with babies of their own." Social service agencies must address the needs of this population more effectively. As Lisbeth Schorr notes, much information exists on how to serve the disadvantaged successfully.²⁸ The question is not whether there is a lack of information or implementation strategies; there are many creative and effective ways to turn those who are disadvantaged into winners. The question is whether our policies and funding priorities will make this transformation possible.

It does not appear that this transformation will occur in the near future, if one relies on current national leadership. President Bush asserted in his 1992 State of the Union address that he wants to cut welfare for those who keep having babies, and to encourage them to find jobs and help themselves. Yet there was no talk of employment opportunities, no discussion about how to help the disenfranchised help themselves, no attack on the sexist, racist, elitist policies that keep the poor in that status. He stated that the poor must be helped, but there must be program, policy, economic, and occupational opportunities to transform rhetoric into action. Minimizing, ignoring, and denying the existence of the problems that lead children to have children, blaming the victims for their own lot in life, and their homelessness only exacerbates other personal and social problems. Those who need to pull themselves up by their bootstraps can do so only when they are wearing boots.

Additionally, young women could greatly benefit from policies that encourage their academic and career development rather than stereotyped female roles. To

prevent homelessness, we must address the issues of gender and economic discrimination while providing adequate intervention services. ♀

I owe special thanks to Fred Bloise, who provided the information about Heidi and Joe.

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Mentally Ill Persons in Emergency and Specialized Shelters

Satisfaction and Distress

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Emergency and specialized mental health shelters represent different service philosophies and are meant to appeal to different segments of the homeless and homeless mentally ill population. This article describes the different characteristics and needs of users of emergency and specialized mental health shelters for homeless persons in Boston. Service satisfaction is described in relation to these characteristics and needs as well as in terms of shelter type. Implications are identified for social and mental health service policies for the homeless.

Seriously mentally ill persons comprise one of the largest and neediest subgroups among the homeless adult population. Representing from 20 to 40 percent of single homeless adults, seriously mentally ill people tend to be more vulnerable on the streets and less adequately served within the emergency shelter system. Yet despite their grave needs, many mentally ill persons remain homeless for lengthy periods, rejected by, or rejecting, traditional mental health services.¹ Although there is general consensus that, ideally, these individuals should be provided with permanent housing and mental health services, insufficient resources have precluded achievement of this ideal for many homeless mentally ill people.²

Special service-oriented shelters for this subgroup represent a partial response to their unique problems. More structured and supportive than large emergency facilities, service-oriented shelters provide a more secure environment and a range of health-related programs, but without the regulations about entry, exit, and program participation that characterize traditional mental health services. Clearly less adequate than independent or supervised permanent housing, they nonetheless fill a niche in the service continuum. Boston is one of several cities in which the state mental health agency has funded special shelters.³

We investigate the role that the specialized mental health shelters play in Boston's service system, employing survey data collected from users of three emergency and two specialized shelters. First, we evaluate the extent to which these shelters are

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used by a particular subgroup among Boston's mentally ill shelter users. Next, we identify differences in feelings of personal distress and service satisfaction among users of the specialized and emergency shelters. Finally, we determine whether intershelter differences in feelings are due to corresponding differences in personal characteristics. Our conclusions highlight policy implications.

Background

Many shelters opened in the early 1980s in response to growing public recognition of the homelessness crisis. Attempting to forestall hunger and even death among individuals who had no discernible means of subsistence, emergency shelters provided food, a place to sleep, and, sometimes, nursing care. Many shelters expected to "work themselves out of business" quickly, and few sought to respond to more chronic problems of their guests; some shelters abjured service provision in order to pressure health and welfare agencies to provide adequate services.

The "emergency" approach to shelter provision was not intended to meet the needs of seriously mentally ill persons, yet early research indicated that many among the homeless were mentally ill.⁴ As the problem of homelessness grew throughout the 1980s, shelter staff found themselves unable to stem the progressive deterioration of these most needy guests. Moreover, mental health agencies often lacked the means or the will to engage potential homeless clients.⁵

Service-oriented shelters for mentally ill homeless persons were a partial response to these problems. Service providers in cities including Boston, New York, and San Francisco sought to provide a shelter environment that at least would be less threatening to mentally ill persons than large, barracks-style shelters and, they hoped, would engage these people in meaningful transitional programs.⁶ Such service-oriented shelters used mental health professionals to engage homeless individuals in treatment-oriented activities. Many offered day programs either on site or through associated mental health centers, and attempted to create a stable, more predictable environment.

In the absence of sufficient housing opportunities for homeless people, particularly for those who are mentally ill, specialized mental health shelters seem to provide an important service option. However, little is known about the role actually performed by these shelters. Service systems for homeless people in most cities are a patchwork of public and private shelters and other programs with varying degrees of coordination, few eligibility regulations, and no central authority.⁷ The mix of users at any particular shelter is determined to a variable and unknown extent by client needs and preferences, physical accessibility, program orientation, and, in some cases, by outreach staff.

Nor is there much basis for predicting the reactions of homeless mentally ill people to particular service approaches. Reports from outreach service providers document disinterest among some potential clients in traditional mental health services and a desire for independent living,⁸ but other studies report that homeless mentally ill persons willingly accept services that are sensitively provided.⁹

Previous research also suggests that homeless mentally ill persons' service experiences and orientations vary with substance abuse: many of the "dually diagnosed" — mentally ill persons who abuse substances — eschew services and are in any case often viewed as inappropriate clients by service providers.¹⁰

These studies do not yield clear implications for predicting or explaining the reactions of homeless mentally ill persons to different types of shelter, although it seems

likely that these reactions will be associated with service interests and thus reflect some of the same influences.

Methodology

Homeless people were interviewed in five Boston shelters: two specialized shelters for homeless mentally ill persons and three generic shelters for homeless adults.¹¹ Both specialized psychiatric shelters are funded by the Massachusetts Department of Mental Health (DMH) and provide beds and a range of services for about sixty persons; one is adjacent to a detoxification center on an island and provides special programs for substance abusers, while the other is located within a downtown Boston community mental health center that offers several day programs. Unlike most generic shelters, the mental health shelters offer permanent bed assignments and lockers, on-site psychiatric nurses and other staff trained in mental health services, and referrals to day and prevocational programs at community mental health centers. A DMH outreach team identifies individuals in the generic shelters or on the streets who might benefit from the special shelters; those who are interested in moving into the special shelters are put on a waiting list until a bed is available.

Each of the three generic shelters is open to all adult homeless persons, basically without restriction (other than for inebriation or past disruptions). As a result, those using these generic shelters are diverse, including some who are employed during the day, others who are medically ill, and many who are substance abusers or mentally ill. Although the generic shelters offer some services for these and other groups — AA meetings, a psychiatric nurse, in-shelter employment programs, and “respite beds” for those recovering from hospitalization — the number of programs offered and the staff/guest ratio are much lower than in the mental health shelters.

Guests at each of the five shelters were asked to participate in an interview between June and November 1990. In the three large “generic” shelters, guests were selected randomly from shelter bed lists. Eighty percent of the guests who were sampled were interviewed.

At the mental health shelters, all guests were asked to participate in an interview; 72 percent agreed. Staff helped to approach them for interviews and small incentives were used to encourage participation.

Interview schedules used in the mental health shelters and in the emergency shelters differed somewhat, but this analysis uses only those questions asked in both settings (see Table 1). Mental health measures used in this analysis are three questions concerning prior or current treatment (with a reliability coefficient of 0.67) and two questions from the Mental Health Inventory — one indicating suicidal thoughts and one indicating feelings of distress or depression.¹² Neither approach indicates actual mental illness at the time of the survey, but both provide evidence of current or past psychiatric problems.¹³

Substance abuse was measured with subsets of items from the Addiction Severity Index (ASI);¹⁴ Cronbach’s alpha for the four-item alcohol abuse scale was 0.78; alpha for the three-item drug abuse scale was 0.84. Available social supports were measured with The 39-item ISEL,¹⁵ which yielded a reliability coefficient of 0.88 (one item was omitted as inappropriate for this population and two were slightly reworded).

Residential experience was assessed by recording the length of time since a person first became homeless and whether the person reported staying with family, friends,

or in a regular place on his or her own since first becoming homeless. In addition, individuals were asked if they had been assaulted on the streets and if they had any legal problems. Satisfaction with shelter arrangements was measured with three individual questions. The subjects were asked to compare the shelter to their last regular housing and to other shelters, and to rate the quality of shelter services. In addition, an index was used, composed of responses to eight questions about such specific shelter features as the amount of room, staff, security, other residents, and convenient location (Cronbach's alpha was 0.77).

Physical health was measured with four questions: rating of physical health relative to others of similar age, satisfaction with physical ability to do things, having been hospitalized or seen by a doctor for a physical health problem in the last year, and having any physical health problem. These questions were combined into an index with a reliability coefficient of 0.66.

Table 1

Individual Characteristics by Shelter Type

Characteristic	Shelter		
	Generic	Mental Health, City	Mental Health, Island
Demographics			
Age: 20s-30s	65%	49%	59%
Education: less than high school	36%	30%	41%
Gender: female	20%	32%	15%
Veteran: yes	16%	13%	7%
Race: white	40%	71%	58% ^a
Social Supports			
Divorced/separated	31%	23%	15%
Children in Boston	24%	13%	12%
Relatives in Boston	61%	61%	56%
Friends in Boston	77%	52%	41% ^b
Interpersonal support evaluation list (ISEL)	2.7	2.5	2.6
Employment and Benefits			
Employed	22%	7%	12%
Looking for work	42%	32%	24%
Received benefits	52%	86%	84% ^c
Health insurance	63%	71%	64%
Difficult to afford things	51%	32%	40%
Residential Experience			
1+ years homeless	55%	97%	82% ^c
1+ years in shelter	46%	53%	54%
Stayed here often	59%	90%	93% ^c
<1 Year since last hospitalized	46%	18%	50% ^{a,d}
Assaulted	44%	52%	62%
Worse physical health	55%	40%	32%
Approximate N	48	31	28

^ap < .05 (difference among three shelter types)

^bp < .01 (difference among three shelter types)

^cp < .001 (difference among three shelter types)

^dp < .05 (difference between two mental health shelters)

Since the focus of this article is on individuals with mental health problems, the analysis of the generic shelter sample is restricted to those sample members who reported any prior or current treatment for mental health problems. These generic shelter users who had been treated for mental health problems were comparable to other generic shelter users in terms of demographic characteristics, social supports, labor force participation, and residential experience. However, previously treated generic shelter users reported poorer physical health, more suicidal thoughts, and more distress (see Appendix).

Because of the potential impact of the expected higher proportion of substance abusers at the island mental health shelter, the two mental health shelters are distinguished in all analyses. The analysis has two goals: to describe the characteristics and needs of persons with a mental health treatment history in the three shelter types and to identify the effect of shelter type on shelter satisfaction.

Cross-tabular analysis is used to achieve both goals, with tests of significance presented for the comparison between individuals staying in the two mental health shelters and those in the generic shelters who had previously been treated for a psychiatric problem. Analysis of covariance is used to identify the unique effect of shelter type on distress and shelter satisfaction.

Findings

Age, education, gender, and veteran status did not vary substantially among the three shelter types (Table 1). The one statistically significant demographic difference between the shelters was in race: more of the mental health shelter users were white, particularly at the central city site.

Few respondents in any setting were married at the time of the interview, and the proportion who were divorced varied little by location. Other indicators of respondents' social relations also varied little between shelters. However, mental health shelter users reported significantly fewer friends in the area than did those at the generic shelters.

Attachment to the labor force varied little by shelter type, although the proportion of guests who were working was somewhat lower at the two mental health shelters. Receipt of benefits, on the other hand, was markedly more common among mental health shelter users.

Length of time homeless was much higher for those staying at the mental health shelters, although this difference did not extend to length of time at the current shelter. In addition, guests at both mental health shelters reported staying there much more regularly since becoming homeless. There was one difference between the two mental health shelters in residential history: it had been much longer since the central city shelter users had last been discharged from a psychiatric hospital. Many respondents had been assaulted or robbed since becoming homeless, but frequency of having been assaulted varied only slightly among guests at the three shelters.

Respondents' self-reported physical health did not differ significantly among the three shelter types, but the generic shelter users had a higher score (indicating poorer physical health) than users of the mental health shelters ($p = 0.1$).

About one quarter of the respondents had thought of suicide within the previous month — a proportion that did not vary significantly among the shelters (Table 2).

Table 2

Current Feelings and Substance Abuse by Shelter Type

Feelings/Substance Abuse	Shelter		
	Generic	Mental Health, City	Mental Health, Island
Suicidal	25%	29%	20%
Down/depressed	48%	29%	20% ^a
Alcohol abuse	40%	30%	50%
Drug abuse	35%	4%	12% ^{b,c}
Approximate N	48	31	28

^ap < .05 (difference among three shelter types)^bp < .01 (difference among three shelter types)^cp < .05 (difference between generic and combined mental health shelters)

Feelings of being down and depressed, however, were much less common among mental health shelter users.

Alcohol abuse was reported by between a third and half of the respondents at each shelter type. The frequency of drug abuse was about one-third in two of the three shelter settings. Users of the central city mental health shelter reported lower rates of both alcohol and drug abuse, although the difference was not statistically significant.

Respondents at the city mental health shelter reported higher levels of satisfaction with their shelter than did the other groups, with almost three-quarters assessing the shelter as better than their last regular housing. However, island mental health shelter users were more likely to believe that their shelter was superior to others (Table 3).

Table 3

Shelter Satisfaction by Shelter Type

Satisfaction	Shelter		
	Generic	Mental Health, City	Mental Health, Island
Satisfied with shelter	65%	87%	57% ^{a,d}
This shelter better compared to last regular housing	47%	72%	41% ^{a,d}
This shelter better compared to other shelters	66%	79%	96% ^{b,d}
Good services	62%	81%	48% ^{a,d}
Move now	57%	48%	65%
Want own apartment	90%	68%	86% ^a
Approximate N	48	31	28

^ap < .05 (difference among three shelter types)^bp < .01 (difference among three shelter types)^cp < .001 (difference among three shelter types)^dp < .05 (difference between two mental health shelters)

Desire to leave the shelter was somewhat lower among central city mental health shelter users than others. Differences in type of living arrangement sought were more marked: two thirds of the central city mental health shelter users wanted their own apartment, compared to nine in ten of the other two groups.

Controlling for length of time homeless and the other individual characteristics associated with shelter type reduced to insignificance the effect of shelter type on feelings of depression: persons who had been homeless longer were less depressed, and such persons were concentrated disproportionately in the mental health shelters (Table 4).

Table 4

Analysis of Covariance of Feeling Depressed by Shelter Type

Main Effect	Degrees of Freedom (DF)		F = Value	P (Probability)
Shelter type	2		.38	.68
<u>Covariates</u>				
Race	1		.56	.46
Financial benefits	1		.04	.85
Friends	1		.88	.35
Time homeless	1		5.22	.02
Explained sum of squares	9.13	DF = 6	F = 1.08	P = .38
Residual sum of squares	119.18	DF = 85		

The effect of shelter type on service satisfaction was independent of the covariates: irrespective of their race, financial benefits, number of friends, and length of time homeless, users of the central city mental health shelter were more satisfied with the services they received at the shelter than either the island mental health shelter users or those in generic shelters who had been treated for psychiatric problems (the greater interest in group living among the central city mental health shelter users also was independent of the covariates) (Table 5).

Discussion

Individuals who had been treated for a psychiatric problem in the generic shelters and those staying in the two mental health shelters were similar in terms of gender, age, and veteran status. There was little difference among guests at the three shelters in frequency of suicidal thoughts. However, mental health shelter users had

Table 5

Analysis of Covariance of Service Satisfaction by Shelter Type

Main Effect	Degrees of Freedom (DF)		F = Value	P (Probability)
Shelter type	2		.38	.68
<u>Covariates</u>				
Race	1		1.12	.29
Financial benefits	1		.71	.40
Friends	1		.29	.59
Time homeless	1		1.40	.18
Explained sum of squares	12.86	DF = 6	F = 2.81	P = .02
Residual sum of squares	51.04	DF = 67		

been homeless longer and were less likely to have friends in Boston; they were also more likely to be receiving financial benefits, appeared somewhat less physically ill, and at the time of the interview felt less depressed.

A tentative explanation of the apparent paradox in these findings — fewer feelings of distress and more financial benefits among mental health shelter users who also had been homeless longer and had fewer friends — is suggested by the concept of “entrenchment”: the adaptation to street or shelter living made by persons who have been homeless for a long period.¹⁶ The potential value of this explanation is reinforced by the ability of length of time homeless to explain the lower distress levels among the mental health shelter users: persons who had been homeless for longer periods were more likely to use the mental health shelters, but wherever they were found, they experienced lower levels of distress.

Users of the two different mental health shelters were comparable in most respects, although substance abuse was less common and latest hospital discharge was less recent among users of the central city mental health shelter than at either the island mental health shelter or the generic shelters. Current feelings differed in several respects between users of the two shelters: central city shelter users were more satisfied with their shelter and more interested in group, rather than independent, living.

The higher level of service satisfaction was not explained by the other differences among users of the three shelters — it seemed more likely to be a product of the shelter experience itself.

There was thus little evidence that the mental health shelters served a clientele that was either more stable or more severely ill, but mental health shelter users did seem to be more entrenched in the state of homelessness.

Homeless persons in Boston's generic shelters who had been treated for a psychiatric problem were similar to other homeless persons in most respects, but they gave many more indications of physical illness and had had more suicidal thoughts. These differences alone suggest the possible need for specialized services for these individuals.

Those who resided at the mental health shelters were similar in many respects to those with a psychiatric treatment history who were using the generic shelters at the time of the survey. However, their more regular shelter use, their higher levels of benefits, their longer time of homelessness, and their less depressed feelings suggest that the mental health shelter users were more adapted to shelter living than their generic shelter counterparts. Central city shelter users were particularly satisfied with the quality of services they received and even tended to rate their shelter accommodations as superior to their last regular housing.

We do not know if the people surveyed in the generic shelters would have moved into a mental health shelter if they had the option, nor do we know if mental health shelter users also had been more satisfied with previous shelter accommodations and less distressed when they were in them. However, the evidence we have reviewed suggests that the mental health shelters were successful in providing a form of accommodation that was viewed as superior to generic shelters and was associated with less distressed feelings. In the chaotic and threatening environment that homeless individuals confront, and in light of the particular vulnerabilities of those who are mentally ill, this is an important achievement.

The appeal of the mental health shelters must be weighed against the vulnerability of their residents to the process of “shelterization”: the acceptance among shelter

users of the state of being homeless, coupled with a decreased interest in independent living, that is also reflected in our findings. The fact that lower levels of distress among the mental health shelter users could be explained by their longer time of homelessness suggests that shelterization may reflect in part the process of entrenchment of individuals in the state of being homeless.¹⁷ It is only within the context of inadequate opportunities for regular housing that our findings can be seen as providing clear support for maintaining mental health shelters.

Our findings also indicate that researchers who seek to understand the sources of depression and demoralization among mentally ill homeless persons as well as the bases of their reactions to service provision must take into account the specific shelter environment to which their respondents are exposed. The widely recognized heterogeneity of the homeless population is now complemented by a differentiated population of shelters. The bases of the feelings of persons who are homeless and mentally ill must be sought in the accommodations and other services they encounter as well as in the other, more personal aspects of their life histories and circumstances. Even the two different special mental health shelters we studied elicited markedly different levels of shelter satisfaction, net of the characteristics of the individuals who use them.

But this study can provide only incomplete answers to the questions we have raised. Longitudinal data must be collected to determine whether the special mental health shelters attract persons who are already more acclimated to being homeless, or instead result in their users' "settling in" over time. More refined measures of mental health status and other key concepts must be used to distinguish situationally induced variation in distress from underlying clinical states. Only comparative studies that draw samples from many different types of shelters will be able to determine which specific shelter approaches elicit higher levels of satisfaction. ♣

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Appendix

Characteristics and Feelings of Generic Shelter Users by Psychiatric Treatment

	Ever Treated for Psychiatric Problem	
	No	Yes
Age: 20s-30s	59%	65%
Education: less than high school	30%	36%
Gender: female	17%	20%
Veteran: yes	27%	16%
Race: white	33%	40%
Divorced/separated	26%	31%
Children in Boston	36%	24%
Relatives in Boston	69%	61%
Friends in Boston	79%	77%
Interpersonal support evaluation list (ISEL)	2.9	2.7
Employed	26%	22%
Looking for work	54%	42%
Received benefits	35%	52% ^a
Health Insurance	46%	63% ^a
Difficult to afford things	29%	51% ^b
1+ years homeless	50	55%
1+ years in shelter	45	46%
Stayed here often	59%	59%
Assaulted	32%	44%
Health: worse	15%	33% ^b
Very dissatisfied	12%	26% ^b
Health problems	41%	62% ^a
Hospitalized or seen by physician	51%	69% ^a
Suicidal	12%	25% ^a
Down/depressed	28%	48% ^a
Alcohol abuse	46%	40%
Drug abuse	33%	35%
Satisfied with shelter	74%	65%
This shelter better compared to last regular housing	32%	47%
Good services	56%	62%
This shelter better compared to other shelters	74%	66%
Move now	65%	57%
Want own apartment	92%	90%

^ap < .05.

^bp < .01.

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The McKinney Act

New England Responses to Federal Support for Assistance to Homeless Mentally Ill Persons

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The Stewart B. McKinney Homeless Assistance Act of 1987 builds on the work of state mental health authorities and the National Institute of Mental Health in the early 1980s. The act and its subsequent amendments are designed to organize, coordinate, and enhance federal support to the states in financing the development of shelter, health, housing, employment, and support services to homeless persons. There is a special focus in the act on assisting homeless persons with handicaps. In the main, the New England states have met the requirements of the act to provide mandated essential services, which include outreach; community mental health, crisis, and rehabilitation services; health and substance-abuse services; training of homeless service providers; case management, including service planning, benefits assistance, and service coordination; and supportive residential services. While the federal funds available are insufficient to cover the majority of costs associated with serving homeless and mentally ill persons, states report their utility in targeting high-needs areas, supporting demonstrations of service innovations, creating incentives for state and local matching funds, and focusing on vulnerable sub-populations. State advocates credit the McKinney Act mental health programs for stimulating localities' interest in and ability to attract HUD funding for housing special needs persons among those homeless. Within the contrary New England economic context, the federal contribution is an important resource and stimulus to state spending.

The New England Mental Health Commissioners Association and the Massachusetts Association for Mental Health have worked collaboratively during the last five years to address major policy, financing, and service issues affecting the region's citizens with mental illnesses. Key issues of concern include poverty; affordable housing; financing of medical and psychiatric services; treatment of co-occurrence of mental illness and substance abuse; organization of service delivery; and empowerment of consumers. There is perhaps no more poignant case of these

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issues coming together than that of persons who are homeless and mentally ill. The work of the state mental health authorities in New England with this population underscores the findings of the Massachusetts Association for Mental Health in its seminal work on homelessness, which began in the late 1970s. As reported in a 1985 association report, the causes of homelessness are many, among them poverty, illness, lack of affordable housing, weak social networks, and limitations in the support services delivery network.¹

Given the multiple causes of homelessness, it should not be surprising that the population of persons without stable housing represents a diverse group with equally diverse needs. Levine notes, "The homeless are a heterogeneous population comprised of many subgroups, including runaway children, immigrants, migrants, so-called bag ladies, displaced families, a certain number of the unemployed, battered women, minorities, the elderly, and an overrepresentation of persons with serious alcohol, drug abuse, and mental health disorders."²

The precise number and proportion of the homeless population who have serious and persistent mental illness is still a matter of some debate. As Robertson says, the empirical research in this area does not provide consistent and reliable estimates across studies.³ Methodological problems, including inconsistent definitions of psychiatric morbidity, differences in sampling frames, and different case-finding methods, make generalizations difficult. However, there appears to be a consensus that approximately one third of single adult homeless persons have severe and persistent mental illness.⁴

In some respects, persons who are homeless and mentally ill are similar to the larger homeless population. Tessler and Dennis, in a review of NIMH-funded studies, concluded that this subgroup mirrored the larger group with respect to age, gender, ethnicity, and extent of substance abuse.⁵ However, the chronic nature of the disabilities affecting those individuals who are both homeless and mentally ill is apparent in their low educational level, poor employment histories, truncated social networks, low marital rate, and high rate of arrest and incarceration.⁶

Policymakers and service providers alike have been challenged as they attempt to meet the myriad needs of this population. It is clear that people who are homeless and mentally ill require assistance in numerous areas, including basic subsistence (food, clothing, and shelter); treatment of mental health, substance-abuse, and physical health problems; and access to income supports. Characterizing homeless mentally ill clients served through a series of NIMH-funded community support program demonstration programs in 1986 through 1987, Hopper, Mauch, and Morse say,

Homeless mentally ill persons are often the most disturbed and most difficult to serve clients within the mental health field. The reasons derive from the difficulty of trying to serve individuals whose needs and circumstances, including a stance of mistrust adapted as a central strategy of survival, badly frayed if not altogether absent social ties, a plethora of basic human service needs, and a high frequency of multiple disorders (i.e., alcohol and drugs, and physical as well as psychiatric problems), pose serious challenges to a service system that is both inadequate in resources and often insensitive to the special problems of the homeless.⁷

The NIMH, as well as other agencies of the federal government and state mental health authorities, has sponsored numerous research and demonstration projects to evaluate service delivery strategies designed to meet the service needs of homeless

mentally ill individuals. While there is, to date, no single simple solution, there is an emerging consensus concerning the attributes of services that are more successful. First, it is clear that the needs of this population transcend the traditional boundaries of mental health systems. Most of these individuals are responsive to offers of assistance; however, their view of their own service needs is frequently different, and more concrete, from that of service providers.⁸ This suggests that more traditional mental health services should be bundled with other services that address people's immediate daily living needs.

Second, the developing body of research suggests that aggressive outreach and intensive case management must be keystone services for this population. Program planners must be sensitive to the extensive amount of time required to engage homeless mentally ill persons in the service system and the stress and fatigue that this causes for front-line workers.⁹ With respect to case management, models that involve low caseloads and long-term support appear to be more successful than models that involve higher caseloads and "brokering" of services.¹⁰

Housing remains a critical need for homeless mentally ill persons. In many states, the supply is dwarfed by the need for affordable housing. Clearly, more housing is needed. However, more housing options are also needed. It is becoming apparent that no single type of housing format will meet the needs of all homeless mentally ill persons.¹¹ What is required is an array of housing options with continuing supports that will last indefinitely.¹² Without these continuing supports, the cycle of homelessness is unlikely to be affected.

While a number of discrete federal government programs were implemented during the early part of the 1980s to address homelessness, the passage of the Stewart B. McKinney Homeless Assistance Act (PL 100-77) in 1987 was designed to organize, coordinate, and enhance federal support to states, cities, and counties. The 1987 act and its subsequent amendments (PL 100-628 and PL 100-625) embody the major commitments of the federal government to combat homelessness and provide states key financial support in the development of shelter, health, housing, employment, and support services to homeless persons.

As Title I, General Provisions, states, the purpose of the act is "to meet the critically urgent needs of the nation's homeless, with special emphasis on elderly persons, handicapped persons, families with children, Native Americans, and veterans." Other titles of the act provide the following:

Title II: establishes an interagency council on the homeless as part of the executive branch to coordinate the federal effort on homelessness.

Title III: establishes a national board to disburse funds to private nonprofit organizations for the Emergency Food and Shelter Program. Authorization of \$134 million for fiscal year 1990.

Title IV: outlines housing assistance initiatives, requiring a Comprehensive Homeless Assistance Plan of eligible states, cities, and counties; provides for emergency shelter grants to open and operate essential shelter services; provides for a supportive housing demonstration program to develop transitional housing and permanent housing with support services for persons with handicaps; provides for a supplemental assistance program to meet special needs of families and elderly and handicapped persons who are homeless that cannot be met under the emergency shelter or supported housing programs; and provides for Section 8 assistance for single-room-occupancy units (SRO) for moderate rehab of SROs. Authorizations

for fiscal 1990 total \$125 million for emergency shelter grants, \$105 million for supported housing demonstrations, \$11 million for the supplemental assistance program, and \$50 million for Section 8 assistance.

Title V: requires the secretary of HUD to identify unused and underutilized federal buildings that are suitable for use by homeless persons.

Title VI: establishes the Health Services for the Homeless Grant Program to support the delivery of primary health care and substance-abuse services to homeless persons — the fiscal 1990 authorization totaled \$63.6 million; establishes the Mental Health Services for the Homeless Block Grant Program (MHSH) and subsequent Programs to Aid in the Transition from Homelessness to support a required set of mental health services to mentally ill persons who are homeless or at risk of homelessness — the fiscal 1990 authorization totaled \$35 million. Also establishes demonstration projects for chronically mentally ill homeless persons — \$11.5 million authorized for 1990 to provide community-based treatment and support to such persons. Also establishes demonstration projects for alcohol- and drug-abuse treatment to homeless persons — fiscal 1990 authorization totaled \$17 million.

Title VII: establishes the Education Training and Community Services Programs to fund adult literacy, education for homeless children, job training for the homeless, homeless veterans' employment reintegration, emergency community services grants, and jobs for employable dependent individuals — fiscal 1990 authorizations totaled \$10 million, \$5 million, \$2.5 million, \$13 million, \$2.2 million, and \$42 million for the respective programs.

Title VIII: provides for shelter and medical care opportunities for homeless veterans — \$30 million authorized for fiscal 1990.

Title IX: provides for Aid to Families with Dependent Children and unemployment compensation, lifting restrictions on states' ability to use AFDC funds for temporary housing needs and funding demonstrations to divert families from welfare hotels to transitional facilities — \$20 million authorized for 1990.

The Stewart B. McKinney Homeless Assistance Act was passed to provide assistance to homeless persons with handicaps. In the act, two provisions directly addressed the needs of persons who are homeless and mentally ill: the Mental Health Services for the Homeless Block Grant (section 611) and the Community Mental Health Services Demonstration Program (section 612, as amended by section 621). Recent amendments created PATH (Programs to Aid in the Transition from Homelessness) to supplant the MHSH Block Grant in 1991. In addition, the provisions of Title I through Title IX of the act address in part the needs of the population. While each of the New England states has applied for and received varying awards of funds from these programs, only the MHSH Block Grant, succeeded by the PATH Program, provide guaranteed funding to the states for the target population.

The Mental Health Services Block Grant provided funds to each of the states and territories to implement services designed to relieve the dual conditions of homelessness and mental illness that affect the target population of the legislation. In 1989, \$14.128 million was allocated to this program. In contrast to the prior year, in which states received grants of varying size according to a formula based on a combined 1987/1988 fiscal year appropriation of \$43.689 million, the 1989 grants were set at \$267,944 for each of the fifty states, the District of Columbia, and Puerto Rico

and \$48,717 for the four territories (Guam, the Virgin Islands, American Samoa, and the Northern Mariana Islands).¹³

In order to receive MHSH Block Grant Funds, states and territories were required to submit an application to the Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) describing high-need geographic areas and services to be provided. All applicants had to execute an agreement assuring compliance with the provisions of the act, including, (1) an agreement that funds would be spent only for the statutory purposes; (2) an agreement to match federal funds with state or local funds at a rate of \$1.00 to \$3.00; and (3) an agreement not to expend McKinney funds on property costs, inpatient costs, and cash payments to service recipients.

States were required to provide services from among six essential categories to persons who were severely mentally ill and homeless or significantly at risk of becoming homeless. Under the provisions (section 524) of the McKinney Act, these included

- outreach services
- community mental health services, diagnostic, crisis intervention, habilitation and rehabilitation services
- referral to medical facilities for inpatient services, and to provider entities for primary health and substance-abuse services
- training to service providers at sites serving homeless people
- case management services, including service planning, service coordination, benefits assistance, service referral, and representative payee services
- supportive and supervisory services in residential settings.

Finally, using a voluntarily agreed-upon uniform format, states were required to report annually on the purpose and amount of expenditures.

In the main, states utilized a range of criteria to distribute MHSH funds. These included:

- Population density: states often referenced population density as the key criterion utilized in evaluating proposals for MHSH Block Grant funds. Others reported equity in allocations to urban areas as their guiding principle, in some cases reserving a small amount to distribute to other areas.
- High-needs target areas: several states, for example, Massachusetts, structured the selection criteria around the results of their survey analyses and needs assessments. Only applications from the highest-ranked need areas, those with the highest percentage of citizens in poverty or with housing problems, were funded. A few states required applicants to demonstrate need and awarded funds according to the ranked percentage of the state's homeless and/or chronically mentally ill population.

- **Qualified agency type:** in other states, the key selection criterion was the type of agency applying for funds. Often, only community mental health centers or state and county mental health entities qualified as applicants. Connecticut and New Hampshire are examples of this practice. Entities in several cases were required to meet the states' community mental health program standards to qualify.
- **Formal review and award criteria:** in a few cases, states awarded funds based on a competitive-bid process, accompanied by a committee review structure utilizing clearly defined award criteria, which included the factors listed above. Review committees were in some cases the State Mental Health Planning Council, in others a specially constituted body of planners and advocates working as part of a state or county homeless task force.

Vermont's process was unique in both its carefully drawn selection criteria and its review group composition. The review group included homeless advocates, providers, and mental health consumers.

- **Other criteria:** other factors utilized by states in the selection process included designation of target service areas; identification of service gaps; previously neglected areas; local availability of housing; proximity to the state hospital; willingness to serve persons with severe mental illness; experience with serving homeless persons; utilization of research data; and ability to collect data. Rhode Island and Maine are examples of this multiple-factors approach.

A diverse array of agencies received McKinney MSHS grant moneys; at least two dozen distinct agency types were reported across the states. The most frequently cited type was a nonprofit outpatient mental health center. The majority of states chose to develop the capability to serve homeless persons within the mental health system as opposed to the generic human service system.

The range of agencies receiving funding included

- **mental health entities:** community service boards, community mental health centers, psychosocial rehabilitation centers, and psychiatric day centers
- **government structures:** a state department of human resources and counties
- **homeless service agencies:** drop-in centers, day shelters, multiservice centers, shelters, Salvation Army, and Travelers Aid Society
- **crisis services:** help hotlines and crisis units
- **health care organizations:** RWJ Healthcare for the Homeless programs, community health centers, a downtown clinic, general hospital, and mobile medical units
- **housing programs:** a neighborhood development agency, transitional living center, and mental health residential programs

- consumer/family organizations: mental health consumer-operated drop-in center and affiliates of the National Alliance for the Mentally Ill.¹⁴

Within New England, New Hampshire is representative of states exclusively funding their community mental health centers. Vermont is representative of a more diverse approach to funding mental health, shelter, community action, housing, and consumer organizations.

The MHSH Block Grant funds have provided states with the opportunity to develop and expand innovative service delivery strategies and improve the lives of homeless and severely mentally ill persons. Some examples cited in the state reports serve to illustrate the magnitude of this impact. Connecticut, for example, noted that prior to the 1989 MHSH Block Grant project, only sixteen of the twenty-two areas in the state designated as the areas of highest need were offering services dedicated specifically to homeless persons with serious mental illness. The 1989 allocation allowed the state to expand services into three areas (encompassing forty-four cities and towns) which previously had no such specialized services.

Other examples of MHSH-funded activities in New England include:

- New Hampshire funded outreach workers in each of its mental health regions. Workers either traveled with a mobile treatment team or were based at a shelter or soup kitchen. They provided a full range of services.
- Rhode Island established a drop-in center offering screening, referral, educational services, and job counseling.
- Rhode Island established a mobile mental health treatment team to provide outreach, mental health services, diagnosis, crisis intervention, case management, and supportive residential services on site wherever homeless persons were contacted.
- Maine established two outreach programs to serve homeless youth. One street outreach worker was based at a group home and the other was based at a counseling program.
- Massachusetts established case management services, assigned to the shelters in its major urban area, Boston, charged with integrating homeless and mentally ill persons into the local mental health system.

A number of state reports provided quantitative evaluation data on the success of programs. Rhode Island, for example, cited the results of an evaluation of its mobile treatment team conducted by the Psychiatric Research and Training Center, a unit of the Division of Mental Health. This longitudinal study of thirty-three dually diagnosed homeless individuals documented success in several areas, including improved housing stability, a 66 percent decrease in contacts with the criminal justice system, a 50 percent reduction in crisis contacts, a 60 percent reduction in hospital admissions, and a 75 percent reduction in the use of detoxification services.

In addition to these notable successes, the reports also document continuing problems and frustrations that plague those attempting to serve this extremely vul-

nerable population. Some states noted that their efforts to evaluate program performance were hampered by the lack of a statewide client-tracking system. This made it difficult to arrive at unduplicated counts of clients served and to document more than the most rudimentary demographic and clinical data on clients. In addition, the nature of service delivery to homeless mentally ill clients, occurring as it often does on the street, in alleys, or in congested shelters, makes it difficult to collect data in any systematic fashion.

Several states also noted that the co-occurrence of psychiatric and substance-abuse disorders presents an extraordinary challenge to service providers. Information in these reports, as well as elsewhere in the literature, suggests that this is a problem of substantial proportions.

States also reported that transitioning clients from homeless team caseloads to mainstream mental health agency caseloads were complicated by limitations in service capacity and the philosophical orientations of more traditional service providers. Similarly, transitions from shelters to housing and from transitional to permanent housing were complicated by a lack of available housing and delays in housing development. These gaps and delays thwarted efforts of homeless program staff to provide effectively for the needs of their clients and increased stress and mistrust among a client population that was difficult to engage.

The McKinney legislation and the resources that were provided to the states through the MSHH Block Grants are important in several ways.

- They have focused awareness on the population of persons who are homeless and mentally ill and provided a template, based on NIMH research findings, for the services needed by this population.
- The legislation has encouraged states to assume responsibility for working with locations to fill gaps in the existing service system.
- The requirement of a match has helped states to leverage state and local funds to assist this population.
- As more and more state economies constrict, this federal assistance assumes greater importance.

The state reports on the 1989 MSHH Block Grant Program provide ample evidence of innovative and creative uses of federal assistance in designing and providing services to homeless persons with serious and persistent mental illness. As a result of this funding, many states were able to develop new services and expand existing services to previously unserved or underserved areas and populations.

In addition, these resources allowed states to increase coordination of services at both the client and system level. States brought together numerous interests, including local advocacy agencies, other agencies of local and state government, and local agencies. Several states also involved consumers in service delivery and oversight roles.

The importance of other federal grant programs was evident in the states' reports of their needs assessment activities. In determining local need, many states relied heavily on data from the NIMH Community Support Program Homeless Demon-

stration grants, the NIMH McKinney Homeless Demonstration grants, the State Mental Health Planning (PL 99-660) grants, and the HUD Comprehensive Homeless Assistance Plans.

States used the federal MSHH Block Grant funds to develop or expand a wide array of services, all aimed at homeless persons with severe mental illness. Funded programs were most frequently embedded within the mental health system, as opposed to the generic human service system providing assistance to homeless persons. Providers concentrated most often on outreach, case management, and referral. Few states provided quantitative data on the effectiveness of the services funded with MSHH money. However, states that conducted formal evaluation were able to document considerable success in the areas of housing stability, hospitalization rates, use of crisis services, use of detoxification services, and integration of clients into the permanent mental health service system.

Several states noted that their monitoring and reporting efforts were hampered by underdeveloped client-tracking systems. The NIMH Mental Health Statistics Improvement Program was developed in recognition of this deficit and the work currently being conducted under this program should assist states considerably in the development of useful systems.

In summary, the federal MSHH Block Grant Program was an important resource for states as they attempted to meet the needs of homeless adults with severe mental illness. It is anticipated that the new Projects for Assistance in Transition from Homelessness (PATH) formula grant program will provide states with increased opportunities to use federal allocations to develop housing and residential services and to develop stronger linkages among treatment, housing, and support services for this population. While annual reports are not due, preliminary reports from the New England states indicate that this is the case. Examples of PATH support activities are as follows.

Connecticut identifies 18,450 persons in the state as homeless. The state estimates that 8 percent to 35 percent of homeless persons are in need of some type of mental health services. PATH funds recently allocated to Connecticut's five mental health regions based on a state allotment formula were then distributed to local mental health agencies. McKinney funds have stimulated the development of a variety of services targeted to homeless and mentally ill persons, including a drop-in center providing outreach, treatment, and referral; an outreach team to streets and shelter; mobile community support to local housing; and case management services to previously unserved persons.

Massachusetts undertook a comprehensive needs assessment of its homeless population, conducted through the Bureau of Census, Shelter and Street Night Operation, in March 1990 and supplemented in February 1991. It identified 6,800 adults who are homeless on a given evening. Of these, 2,500 reside in Greater Boston. Three thousand are single persons, 9 percent of whom have a serious mental illness and 12 percent of whom have a co-occurrence of mental illness and substance-abuse problems.

Based on the survey information, Massachusetts designated the PATH Grant to fund fifteen full-time equivalent (FTE) master-level clinicians to provide outreach, treatment, and support to the major shelters in Massachusetts. An additional 2.5 FTE housing advocates would be funded to identify and access housing support. Massachusetts provides outreach and case management services to sixty-one

shelters, offers four training sessions to shelter staff, and has a goal to place 50 percent of identified homeless clients with serious mental illness in affordable housing and secure income support for 70 percent of them.

Maine estimates that it has 350 to 450 homeless persons, of whom 117 to 150 have serious mental illness. The annualized number of homeless is ten times this figure. In addition, the state has 52,000 adults and 3,000 children who are at risk of becoming homeless, according to the study of the Maine Task Force to Study Homelessness.

Maine uses PATH funds to provide outreach and case management programs in six of its seven regions. All services are delivered through private mental health agencies, usually community mental health centers and specialized adolescent programs with experience in serving mentally ill youth with substance-abuse problems. Adult services focus on outreach and case finding to most of the major shelters in the state, case management for identified clients, and training for shelter staff. Children's services involve outreach to adolescent agencies and specialized children's shelters.

The state expects to engage a significant portion of these in mental health services, with a limited number being placed in stable housing. Services provided include street outreach, home-based counseling, and group residences for youth; case management, benefits advocacy, and residential support to adults; and training and technical assistance to shelter providers.

New Hampshire identified 14,415 homeless persons who were served in 1988. New Hampshire uses PATH moneys to support existing (MHSH) case manager and homelessness coordinator positions at each of its ten regional community mental health centers. It provides assertive case management in three regions and supports continuous treatment teams at seven regional CMHCs. The teams offer community mental health services, habilitation and rehabilitation, referrals, and training. All the centers also provide substance-abuse services in their respective regions. New Hampshire is distinguished in its work with individuals with co-occurring mental illness and substance-abuse problems.

The homeless coordinators provide linkages to housing agencies, shelters, and the general public on homelessness issues. Each is also the contact person within the agency to coordinate mental health support to individuals in shelters, through referral to other center clinical staff. New Hampshire emphasizes that services to homeless persons are a high priority and that there is coordination of services through the New Hampshire Task Force of Homelessness, as well as through ongoing communication between the State Office of Alcohol Abuse and Drug Prevention and the Division of Mental Health and Disability Services.

Rhode Island statistics indicate that 18 percent of Rhode Island's homeless citizens have a serious mental illness and 10 percent have a co-occurrence of mental illness and substance abuse. Rhode Island funds CMHCs in three counties, using five nonprofit agencies to deliver services. In Providence it funds a drop-in center at the Travelers Aid Society that serves 2,000 homeless persons annually and an outreach team from the Providence Mental Health Center that generates a similar number of contacts. In Newport it funds the CMHC's mobile treatment team, as well as support services at a transitional shelter and drop-in center. Mobile treatment teams from the Kent County and northern Rhode Island community mental health centers are also supported with PATH resources.

The Providence and Newport programs provide outreach, case management, community mental health services, and substance-abuse treatment to persons who are actually homeless. Similar services are offered in Kent County and northern Rhode Island to individuals who are at risk of becoming homeless. Rhode Island's CMHCs are licensed providers of substance-abuse services and therefore have the capacity to ensure integrated services to homeless persons with a co-occurrence of mental illness and substance abuse.

Vermont estimates that there are approximately 700 homeless and mentally ill citizens it targets for service through McKinney funds. PATH funds are contracted to six areas of the state. The types of agencies funded range from consumer-directed drop-in centers to community mental health centers to neighborhood development organizations. Each provider is required to target individuals unserved by mainstream mental health agencies, to provide services in clients' natural settings, and to meet the full range of needs, including housing and support services. Although the majority of programs focus on adults, one agency targets children and youth. Vermont is distinguished in the application of its nationally recognized supported housing model to meeting the needs of homeless persons.

In summary, the Stewart B. McKinney Homeless Assistance Act and the recent PATH provisions offer opportunities for the states to address the needs of homeless citizens across the nation. While the funds available are insufficient to cover the majority of costs associated with services to homeless persons, states report their value in targeting high-need areas, supporting demonstrations of service innovations, creating incentives for state and local matching funds, and focusing on vulnerable subpopulations of homeless persons like those with severe mental illness. Of particular value in the effort to serve homeless individuals with mental illness are the recent McKinney Act provisions designed to foster cooperation between the homeless provider network and mainstream mental health agencies, integration of health care and mental health care to homeless persons, coordination of mental health and substance-abuse services to those with co-occurring disorders, and joint funding of NIMH service demonstrations to complement HUD-supported housing initiatives.

States' advocates credit the McKinney Act mental health programs for stimulating localities' interest in and ability to attract HUD funding for housing special needs persons among those homeless. The interplay of multiple federal programs, state dollars, and private matching funds within local service organizations has produced innovation, filled gaps in the continuum of care, and supported alternative service approaches more effective in meeting the needs of those homeless and mentally ill persons who have been disconnected from traditional mental health services. In most jurisdictions, McKinney funds have provided the support needed for surveys to identify the scope of the problem of homelessness among mentally ill persons. While resources remain woefully inadequate to meet the need, within the contrary New England economic context, the federal contribution is an important resource and stimulus to state spending. 21

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My Life

Thomas Newman

Becoming Homeless

On April 1, 1986 I became homeless when my father's house caught fire. The first two or three nights I stayed in my father's camper and then after that I stayed in the house. At that time I was working 3rd shift in a plastics company. About a week after the fire I bought a car from a friend at work and I lived in the car for about five months. On the night I bought the car I lost my job because I missed a couple of nights of work because I stayed in the house without electricity and I did not have a clock to wake me up at night. One of the reasons I could not get up for work was my father had me helping him take things out of the house during the day and take them to a storage place. When he had me helping during the day I should have been sleeping.

For the five months that I lived in my car I showered at a friend's house and worked odd jobs here and there. In August a friend got me a job at a plastics company working 2nd shift. When I would get off work we would go to a bar to kill time and then about a week later I started to go to a bar to have a few beers before I went to work. Then I would not go to work or I would go in late. Then I ended up getting fired from that job. At the time I was eating once or twice a week.

The Revolving Door

On September 24, 1986 I went to the V.A. Hospital. They admitted me about two or three days later. Someone from the alcohol ward came to talk to me about going into the program. I went into the program for 28 days and then they had me go to a half way house. I stayed there for 30 days and then I left there. Went back to my car and lived there two nights. Then one night my father came by and told me I could stay at his house. That was in December, 1986.

I was getting TDI checks every week. In January, 1987, I got a dishwasher job. A few weeks later I got hit by a car on my way to work. I did not get hurt bad, I just got a cut on my right leg with two stitches. After I left the VA Hospital, I started to drink again and later that night I took an overdose and ended up at the VA Hospital. I was

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there for about a week. When I got out I went to my father's house for a few days. When I went to pick up my pay check my boss told me I was fired.

A few days later, I called my old boss at the plastics company and got my job back. After a week I started to get depressed again and I started to drink again. I was having stomach pains. I went to the VA Hospital. They admitted me for tests. When I got out I went to a bar and ended up back in the VA Hospital that night. About two days later they had someone from the alcohol ward come to talk to me. I went through the programs and they sent me back to the half way house. I stayed there for two weeks and then I left. For about two or three weeks I slept in the streets on a hill near the VA Hospital under some trees.

More Bouncing Around

One night I had gotten drunk and ended up in the VA Hospital and they had the police take me to the Salvation Army for the night. The next day I joined their alcohol program. After a week in the program, my back and hip started to hurt me and I asked my counselor for a job with no heavy lifting. He kept telling me to come to see him tomorrow. After a week of that I left there.

This was at the end of August 1987. I went to Amos House shelter, went to work at a temporary job place. My father found where I was staying at the shelter and called me to tell me I could stay at his house till I could save some money to get an apartment. So I went to his house the next night. After a few weeks I started to get depressed again. I went to a bar and got drunk. When I got home I took an overdose and ended up in the Cranston Hospital.

When I got out I went back to my father's house. That night my aunt called me and asked if I could stay at her house for a few weeks and I told her that I could. So my father took me to her house that night. A few days later a friend of mine told me that where he was working they needed help. I got a job that started the next day, in December, 1987.

I got laid off. I got drunk a week later and stayed in a hotel for a night. When I went back to my aunt's house she told me after New Year's I would have to leave. I went to a shelter and was working at the labor pool. After work each day I would go out to a bar and get drunk. One night I left the bar too late to get into the shelter so a friend of mine brought me to the emergency shelter.

The Beginning of Hope

The next day I went to Amos House shelter and stayed there that night. The next day I went to the emergency shelter because they were staying open 24 hours a day for the weekend. I was going to go back to Amos House that night but I met a young lady with a 4 year old girl and a 2 year old boy. The boy was sick so I stayed to help her with the kids. That Thursday, welfare put them in a hotel for a week. The next day her and her brother came to get me and I stayed at the hotel with them.

There was me, her, the two kids, her brother, her mother, and her mother's husband staying there. After the week was up we went back to the emergency shelter.

We were together for almost one month and I fell in love with her and her two kids. After four days in the emergency shelter they went to Massachusetts. When they said goodbye to me at the bus station I knew I wouldn't see her again. After a few days,

between the depression and her leaving, I started to drink again. I got to a point where I did not care if I lived or died. In fact, I wanted to die at first.

Then in April, when I got \$500 from income taxes. I went drinking till I had no money left. On April 24, 1988, I went to the Benjamin Rush Detox Center for a week. When I got out I went to the Travelers Aid and they put me up at the Salvation Army. They paid for two or three nights. I got a job, started to work, and I stayed at the Salvation Army till I got my first pay check. Then Traveller's Aid got me a room at the Providence YMCA.

For 9 months I stayed sober. My back and hip started to bother me and around Christmas I went into a deep depression and I quit my job. On December 28, 1988 I went to the VA Hospital to try and get treated for the depression but they treated me for alcohol and sent me to another halfway house. I stayed for a week.

Another Downward Cycle

I went to the Welcome Arnold Shelter January, 1989. I met another girl. She was 30 years old and had a daughter and a son. I helped her for a while and Traveler's Aid got her into a women's shelter and a few days later I got an apartment. I was going through different mood swings and on April 3, 1989, I was depressed and got kicked out of the apartment. Rather than to end up in a shelter again I took another overdose and almost died on April 4, 1989. I woke up out of a coma at about 1 p.m. I was in R.I. Hospital.

Two days later they sent me to the VA Hospital. After a week in the hospital all they wanted was to treat me for alcohol so I left the locked ward I was on and went downtown, went to a bar. About three or four hours later the VA had the Providence Police bring me back to the VA Hospital. After that, the VA treated me for the depression. They put me on an antidepressant and a week later let me out of the hospital. I was out on the streets again and had no place to go.

I went into a panic and took another overdose and ended up in the VA Hospital. While I was in the VA I called Traveller's Aid and found out that I could get a room back in the Providence YMCA. After three weeks living in the YMCA, I moved out of there and went to the shelter to try to save some money for an apartment that did not cost so much money.

Coming Together

I was going to the "Housing Now" meetings and rallies and I met someone from Newport. He told me about the old YMCA. In August, 1989, I applied for a room and on September 22, 1989, I moved to Newport and stayed in the shelter. On October 6, 1989, I went to Washington, D.C., for the "Housing Now" march.

On November 20, I got a room in the old Navy YMCA and got a case manager at the Newport Mental Health Center to get treated for my depression. But I kept getting drunk and my alcohol counselor and my case manager wanted me to go into a half way house. But I did not want to go to one, so I told my case manager that I had a week's sobriety and to give me three more weeks to stay sober, and that if I did pick up a drink I would [go] to Benjamin Rush Detox. And in February, 1990, I went to Washington, D.C., for a three night sleep out for the Right to Housing, trying to get the Senate and Congress to pass a bill so that more affordable housing can be built.

I came back to Newport February 14. That Saturday I was depressed. When I woke up I started to drink, got suicidal and the police took me to Newport Hospital. I stayed

there for about fifteen minutes and went back home, locked myself in my room for three days. When I saw my case manager on that Tuesday she asked me if I remembered the promises I made her and I said I did and told her that I would go to the Benjamin Rush Detox Center. I was there for eight days and started Antabuse to help me stay sober. I got thirty days' sobriety. And then I got started on an antidepressant.

I am going to AA meetings and I have a different outlook on life and about myself, thanks [to] my case manager caring about me and making me see that I am not worthless and that I have something to live for. And now I plan to take a course from the New York Institute of Photography and sometime in the future I hope to be a photographer.

Why I Wrote This Story

The main reason I wrote this is to let people know the people who are homeless are not alcoholics, druggies, that anybody can become a homeless person and that there are families out there without a home. There are women and children who are homeless and maybe someday that bill will get passed and then there won't be a need for shelters. ♀

Financing Mental Health Services for the Homeless Mentally Ill in New England

Margaret Stephens
Dominic Hodgkin

This paper examines how New England states pay for the mental health care of the homeless mentally ill. The focus is on how states choose providers, how they reimburse and monitor them, and how these arrangements may affect the incentives facing providers. Detailed case studies of Massachusetts, Rhode Island, and Vermont regulations are included. The studies reveal important differences in how states choose and reimburse providers, for both the homeless and nonhomeless mentally ill. The states also differ in the extent to which they have contracted with nontraditional providers, which many believe to be a necessary approach, given the frequent unwillingness of homeless persons to use the traditional mental health care system. The authors recommend investigation of the health, housing, and cost outcomes associated with these interstate differences in reimbursement policy, as the relationship may offer insights relevant to ongoing policy reforms.

During the 1980s, New England's strong regional economy allowed the states to develop new services targeted at the homeless mentally ill, whose numbers were surging partly as a result of deinstitutionalization policies. The regional fiscal climate in the 1990s is less favorable, due to the recession and voter hostility to taxes, as a result of which states are scrambling to improve the cost-effectiveness of their spending on human services. As a result, there is increasing interest in the effect of contract and reimbursement design on the delivery of human services. In this respect, the New England states provide a potentially instructive set of comparisons, given their historically widely divergent patterns of contracting and reimbursement procedures for human services.¹

Our aim is to examine in detail how mental health services for the homeless mentally ill are paid for in three New England states, and note where differences have implications for policy discussions. We explain why we think that the design of provider reimbursement is relevant to the delivery of human services, including care of the homeless mentally ill, note constraints common to all New England states, and

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present detailed case studies of provider reimbursement in Vermont, Massachusetts, and Rhode Island. Finally, we discuss our results and draw a few conclusions.

Issues in Provider Reimbursement

In analyzing the financing of mental health care and other human services, it is useful to distinguish the purchaser-provider relationship from the relationships among various purchasers (for example, federal government, state government, local mental health boards). Some previous research has addressed the issues involved in design of intergovernmental transfers in mental health,² and the sources of state mental health financing in New England.³ In contrast, we focus on purchaser-provider relationships building on earlier work on state contracting in mental health.⁴

A key question in evaluating human service contracts concerns the way the unit of service is defined and performance is evaluated. These questions arise because human service contracts typically pay providers according to their use of inputs rather than outputs, owing to the equity and incentive problems that could result if providers were paid solely by results. For an example of the incentive problems, consider the effect of a state policy guaranteeing to pay providers only for those homeless mentally ill persons successfully housed and placed in treatment. Rather than maximizing total outreach, this payment system would offer clear incentives for a provider to seek out those homeless people most likely to respond to outreach and ignore others, despite their possibly greater need. Although in principle the state could prevent such an outcome by adjusting provider payments for case severity, in practice the informational and administrative requirements for doing so would be prohibitive for many human services, including, presumably, treatment of the homeless mentally ill.

The alternative usually found in human services is to contract for inputs, that is, to pay providers based on hours of care provided or numbers treated or according to a set budget. Where funding is affected by the success or failure of the program, the effect occurs only with a lag, for example, through eventual nonrenewal of contracts if performance is deemed unsatisfactory. In turn, this choice of payment system means that one must pay extra attention to the incentive effects of how inputs are reimbursed and how performance is measured.

A second set of issues concerns the process by which the contract is awarded. Design issues include how the state decides who is qualified to bid, whether it makes regular use of requests for proposals (RFP), and how it selects the winning bid. Again, the risk of unobservable quality variation is one reason why states may not always choose the lowest bidder for a contract. Other reasons include the desire to keep a wide pool of potential bidders for future contracts, concern for continuity of care, or lobbying on behalf of particular bidders by legislators, human service professionals, and consumers.

A possible objection to the above approach would be that human service providers differ from, say, manufacturing subcontractors in that they are altruistically motivated. By implication, they would not respond to apparent incentives in a profit-maximizing way, if this would harm patient care. This argument has some validity, but there is also evidence of providers avoiding hard to treat or disruptive mental patients in the absence of special subsidies for treating them.⁵ The best research

strategy is probably to treat this as an empirical question, with provider altruism (no effect of incentives) being one possible hypothesis to test against others.

Although our focus is on homeless-specific reimbursement issues, the case studies also provide some background on mental health reimbursement in general. One reason this is important is that the homeless mentally ill are likely to be affected by the design of mental health contracts in general, not only those targeted to the homeless. For example, poorly designed performance incentives in general contracts may lead mental health providers to avoid the homeless mentally ill.

The Overall Environment

It is worth noting a few issues common to all states. First, all program planners face problems in determining the size of the population for whom they are developing programs. Estimates of homelessness in the United States range from 250,000 to 300,000 (U.S. Department of Housing and Urban Development) to 735,000 (National Alliance to End Homelessness). To further compound the problem, surveys report that anywhere from 10 to 47 percent of the homeless are mentally ill.⁶ The difficulty arises partly from the lack of a standard definition of homelessness (currently or at risk of; chronic or episodic) and partly from a lack of staff at shelters who are trained to diagnose mental illness. Surveys may report number of homeless individuals on any given night, over the course of a year, or served in shelters. All our estimates are subject to this imprecision. While they are the best guesstimates of knowledgeable state officials, these numbers should in no way be considered as definitive counts.

Another common theme is the difficulty of persuading the homeless mentally ill to accept treatment from traditional providers such as a community mental health center (CMHC). For the homeless mentally ill population, CMHCs may appear unattractive because there is a certain amount of pressure to follow a full treatment plan. For example, if medication is prescribed for an individual but not taken, there may be pressure in counseling or other treatment sessions to take the medication. Day treatment programs may combine homeless individuals with others with whom they feel they have little in common.

This has obliged states to make use of alternative providers such as shelters or food banks, which often operate outside the formal mental health system. In turn, the states' use of such providers poses a separate problem of how far to integrate their reimbursement and contracting arrangements with those used for traditional mental health providers.

Another constraint shared by all states is the existing organization of federal financing for care of the mentally ill homeless. Because of the federal system's critical importance for the states' own efforts, we describe it in detail.

The federal government currently awards funds to states for the provision of services to persons with severe mental illness who are homeless or at risk of homelessness through the Projects for Assistance in Transition from Homelessness (PATH) formula grant program. This program is a replacement for and an expansion of the McKinney Mental Health Services for the Homeless block grant program (MHSH) and is administered by the National Institute of Mental Health (NIMH). Under this program, Congress is authorized to appropriate \$75 million through 1994; the fund-

ing level for fiscal year 1991 was \$33.1 million and \$30 million has been appropriated for 1992. A state submits an annual application to NIMH and designates a state agency to administer the program. For every \$3.00 it receives in federal funds, a state must make a \$1.00 contribution in cash or in kind. Table 1 provides a comparison of the PATH and MSHH programs.

Table 1

Comparison of PATH and MSHH Federal Programs

	PATH	MSHH
Appropriation	\$33 million (FY 1991)	\$28 million (FY 1990)
Target Population	Individuals with serious mental illness and those with serious mental illness and substance-abuse disorders who are homeless or at imminent risk of becoming homeless	Individuals who are chronically mentally ill and homeless
Forms of Assistance	Formula grants to states, District of Columbia, Puerto Rico, and the U.S. territories	Block grants to same
Eligible Entities	States, which must make payments to political subdivisions of the state, and nonprofit private entities, including community-based veterans organizations and other community organizations	States, which must use funds to provide community mental health services to homeless individuals
Matching Funds	For every \$3.00 of federal funds provided, a \$1.00 match in public or private non-federal funds; match may be in cash or in kind	Same
Required Services	Same as MSHH, plus screening and diagnostic treatment services; habilitation and rehabilitation services; alcohol or drug treatment services; housing services; other appropriate services	Outreach; community mental health services; referrals; staff training; case management; supportive services in residential settings
Housing Assistance	Up to 20 percent of payment may be used for housing services, including minor renovation, expansion, and repair; planning for housing; technical assistance in applying for housing assistance; coordination of housing and services; security deposits; cost of matching individuals with appropriate housing situations; one-time rental payments to prevent eviction.	None
Restriction on Funds	No more than 20 percent for housing services; no more than 4 percent of total allocation for administrative expenses. Payments may not be expended for emergency shelters, housing construction, inpatient psychiatric or substance-abuse treatment, or cash payments to recipients of mental health services.	State agency may not spend more than 4 percent for administrative expenses. Payments may not be made for inpatient services, cash payments to clients, purchase or improvement of property, purchase of medical equipment, or to satisfy required nonfederal match.
Allotment of Funds	Minimum allotment: \$300,000 for states, District of Columbia, and Puerto Rico; \$50,000 for U.S. territories. Allotment determination formula: based on percentage of population living in urbanized areas of the state versus percentage of population living in urbanized areas of United States.	Minimum allotment: \$275,000 for states, District of Columbia, and Puerto Rico; \$50,000 for U.S. territories. Allotment determination formula: same as PATH.

Source: Access 3, no. 1 (January 1991): 5.

Two major differences are worth noting. First, individuals with a dual diagnosis of mental illness and substance abuse may not be excluded by any agency that receives PATH funds. Second, additional services, including housing services, are authorized under PATH. Housing services may include planning and coordinating housing services; providing technical support to those applying for housing assistance; matching people with appropriate residential programs; minor renovation, expansion, or repair of residences; and one-time rental payments to prevent eviction.⁷

State Studies

The case studies of three New England states were chosen partly for their contrasting approaches to reimbursement and contracting. Where appropriate, similarities/differences with other New England states will be noted. Table 2 contains information on the three states we discuss in detail: Massachusetts, Rhode Island, and Vermont. For comparison, Table 3 provides the same information for the remaining New England states.

The information on states' contracting practices was collected primarily through conversations with officials in the government agency responsible for overseeing the mental health service system in each state and through examination of sample documents supplied by the officials. Our analysis has not been reviewed by anyone within these agencies. We take full responsibility for any errors or omissions in this article.

Table 2

State Comparisons

	Massachusetts	Rhode Island	Vermont
Population (1990)	6,016,000	1,003,000	563,000
Area (square miles)	10,555	1,545	9,615
Percent of Population in Metropolitan Areas	90.4%	92.5%	23.4%
State Mental Health Agency	Department of Mental Health	Division of Mental Health and Community Support Services	Division of Mental Health
Community Mental Health Service System	State-operated CMHCs; contracts with private providers	Contracts with private providers; CMHC responsible for specific area	Contracts with designated private providers; CMHC responsible for specific area
PATH funding	\$862,751 (FY 91) \$706,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)
Services to Homeless Mentally Ill	Shelters: 2 DMH, 1 contracted; DMH-operated outreach team; contracts for psychiatric nurses at shelters and for detox center	4 CMHCs offer outreach, mobile treatment; non-CMCH operates drop-in center	Contracts fund staff positions at generic, antipoverty organizations
Funding Process (private providers)	Five-year RFP cycle	Annual budget – negotiations with existing contractors; RFP for new services	Annual budget negotiations with designated providers; annual funding application for providers of homeless mentally ill services

Sources: *Statistical Abstract of the United States*, 1991; state mental health plans as referenced in text; state mental health agency officials.

Table 3

State Comparisons

	Connecticut	Maine	New Hampshire
Population (1990)	3,287,000	1,228,000	1,109,000
Area (square miles)	5,544	35,387	9,351
Percentage of Population in Metropolitan Areas	92.4%	35.9%	56.1%
State Mental Health Agency	Department of Mental Health	Bureau of Mental Health	Bureau of Mental Health Services
Community Mental Health Service System	State-operated CMHCs; contracts with private providers	Contracts with private providers	Contracts with approved private providers; CMHC responsible for specific area
PATH funding	\$449,325 (FY 91) \$366,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)	\$300,000 (FY 91) \$300,000 (FY 92)
Services to Homeless Mentally Ill	State CMHCs offer outreach and case management; contracts for case management and outreach to shelters	Contracts for outreach and supportive services at shelters; intensive case management in most areas	CMHCs provide outreach, case management, shelters; local groups operate housing and loan programs
Funding Process (private providers)	Annual budget negotiations with existing contractors; RFP for new services	Current — annual budget negotiations with existing contractors; RFP for new services; 1996 — six-year RFP cycle	Annual budget negotiations with existing contractors; RFP for new services

Sources: *Statistical Abstract of the United States*, 1991; state mental health plans as referenced in text; state mental health agency officials.

Massachusetts

The commonwealth of Massachusetts covers an area of approximately 10,500 square miles and has about 6 million inhabitants (1990 estimate). The Department of Mental Health (DMH), a subdivision of the Executive Office of Human Services, oversees the provision of mental health services to children and adults in the commonwealth. In 1990, the administrative structure of DMH was reorganized; separate area, regional, and inpatient administrative offices were consolidated into nine service delivery areas.⁸

The DMH had a fiscal 1991 budget of over \$450 million, of which 50.53 percent was allocated to purchased and contracted services, with the remainder funding services operated by the state. Private contractors provide virtually all residential services and more than three quarters of emergency services and skill development/employment services. Case management and adult inpatient services are almost completely provided by the state. As of April 1991, DMH had approximately 1,400 contracts totaling \$199 million. Of these, approximately 1,000 contracts were for mental health services, with the remainder covering such varied services as laundry and medical laboratory services.⁹

At the beginning of 1991, the regular DMH service delivery system included sixteen DMH-operated facilities: seven state hospitals for adults, one facility for children, and eight community mental health centers. In June 1991, the Governor's

Special Commission on Facility Consolidation submitted a report recommending the closure of three of the hospitals and the restructuring of acute inpatient services. The commission plans to submit its recommendations on the community mental health centers and the children's facility later in 1992.¹⁰

DMH has begun to act upon these recommendations: closure of one of the hospitals has been completed, and DMH is currently evaluating the responses to a request for proposals for the development of acute care inpatient units in community and private hospitals. Some patient advocates and providers have charged that the numbers of homeless mentally ill are increasing sharply as a result of the facility closures and the recent elimination of General Relief welfare benefits for the mentally ill.¹¹

It is estimated that there are between 2,500 and 3,000 homeless mentally ill individuals in Massachusetts, with 1,500 to 2,000 in the Metropolitan Boston area alone.¹² DMH has focused on improving the collaboration between shelters and the existing mental health system in order to reach the homeless mentally ill population and improve their access to the service system. Each DMH area is required to have an agreement with every shelter within its boundaries which describes the provision of clinical, case management, crisis, and educational services to the shelter. In addition, it is DMH policy that homeless individuals be given priority for case management services.¹³

In the Boston area, the Department of Mental Health operates two shelters for homeless mentally ill individuals and contracts for a third. The aim of these shelters is to stabilize clients rather than provide temporary shelter; staff are clinically trained. DMH also operates a homeless outreach team in the Boston area whose function is to visit area shelters and provide case management services for mentally ill residents. This team also performs street outreach.

DMH contracts with five non-DMH shelters in the Boston area for the provision of a total of 10.2 full-time equivalent (FTE) psychiatric nurses who function as stabilizing forces at the shelter sites. The nurses refer clients to the homeless outreach team and confer with them on case management decisions. They are responsible for general health care issues as well and network with other shelters and providers; due to the numerous providers of different services to the homeless, networking is necessary to maintain the flow of information to all caregivers involved with an individual. Nurses often have input into policy and program development decisions as well.

DMH and the Department of Public Health jointly fund a contract with an organization that operates an intensive care detoxification center for substance-abusing homeless mentally ill individuals.

Federal MSHS funds have been used to support 19.5 FTE shelter specialists in shelters throughout the state. In addition to providing direct care, shelter specialists refer clients to entitlement, training, and education programs and to community mental health centers or substance-abuse treatment providers. For the current year, DMH hopes to use 2.5 FTE to fund housing services advocates who would act as consultants to the shelter specialists, provide technical assistance to clients referred by them, and seek out available existing housing.¹⁴

DMH has made development of housing a priority, which is evidenced by the fact that within the last five years, in the Boston area alone, 400 units of housing (500 if independent-living apartments are included) have been developed and there are agreements for the development of over 400 more units within the next eighteen

months. Also in Boston, 215 residential beds have been set aside for the homeless mentally ill with half the individuals coming from DMH shelters and half from inpatient facilities. DMH has contracted with a variety of private nonprofit organizations to provide these beds and gives the local community mental health center the responsibility for programmatic oversight. The problem DMH faces is being able to provide the funding for the necessary supportive services.

This problem was reported in Maine as well. In 1989, Maine voters approved a \$7 million housing bond referendum, which has since been leveraged into a \$12 million mental health facility fund being used for acquiring and rehabilitating residential program sites. A request for proposals was sent out in 1991 for the development of residential projects in nine areas of the state, which will result in at least 54 additional places for mentally ill adults. However, funds for operating costs and supportive services are not adequate to allow financing of all the proposals the Bureau of Mental Health would have liked.¹⁵

The Code of Massachusetts Regulations, Chapter 808.200, details the procedures state agencies must follow when purchasing social services. Contracts for all services performed by private providers must be opened to rebidding at least once every five years. A request for proposals is developed which describes the services sought and the evaluation criteria and must include price information — the schedule of prices or price methodology.¹⁶

The Massachusetts five-year RFP cycle is unique within the New England area. As will be discussed in more detail below, the RFP process is used in Rhode Island to develop new programs; however, once chosen, the contractor becomes a sole source provider. In Connecticut, a similar process requests grant applications for the development of new programs. After the initial year of operation, however, the program is funded through a separate process. Funding is requested through plans submitted by area directors to the Connecticut Department of Mental Health, which separates programs into two categories: continuation and expansion or new programs. The legislature specifies funding levels for each category. Thus, again, the contractor becomes a sole source provider. In further contrast, the Connecticut Department of Mental Health is under no obligation to put out contracts for competitive bidding for new or expansion programs as is the Massachusetts DMH.

The Massachusetts request for proposals process begins with publication of a notice in the *Goods and Services Bulletin*. The notice includes a brief program description, deadline information, and a contact within the contracting state agency. The department seeking to purchase services is required to “disseminate notices of availability of the RFP in a manner designed to obtain the widest possible competition at least 20 calendar days prior to the deadline for submission of proposals.”¹⁷ A bidders’ conference is held at which bidders may ask questions about any aspect of the RFP or the RFP process. Prior to submission of a proposal, all bidders must be qualified by their principal purchasing agency, that is, the agency within the Executive Office of Human Services which has awarded the greatest total contract dollars to the provider in the most recent fiscal year. Qualification requires the submission of financial and organizational data that demonstrates a bidder’s ability to meet minimum administrative and fiscal standards.

In general, proposals must include a description of the program, a proposed budget, an agency and/or program organizational chart, job descriptions for all program staff positions, proof of license, if required, and certification from the State

Office of Minority and Women Business Assistance (SOMWBA), if applicable.¹⁸ Further qualifications and/or requirements may be specified in the RFP itself. Contents of the proposal may become part of the final contract.

Proposals are required to be evaluated according to the priorities and programmatic guidelines specified in the RFP. Proposals are initially screened to ensure that they meet the minimum requirements and conditions contained in the RFP. A selections committee, whose members must include at least three state employees, is formed to review these proposals and make a recommendation to either the area director or the central office, whichever level is purchasing the services, who may then accept or reject the recommendation. An RFP may be withdrawn at any time during this process and a new RFP issued.¹⁹

The department may also initiate competitive negotiations with all qualified bidders, during which the original specifications in the RFP may be modified as long as it is reasonably believed that organizations which did not bid on the original RFP would not have bid had the modifications been included.²⁰

Contract negotiations are limited to terms and conditions that were not specifically addressed in the RFP or the proposal. If the division cannot reach agreement with the first prioritized bidder after a reasonable time, it may disqualify that bidder and begin contract negotiations with the next prioritized bidder.²¹ Unsuccessful bidders may request a meeting with the department to discuss the reasons a competitor's proposal was selected and may appeal the decision to the head of the department, and if still dissatisfied, may appeal the department head's decision to the assistant commissioner of the Division of Purchased Services.²²

There are two additional methods of procuring services: prequalified services procurement and noncompetitive procurement. If a department is unsure of the amount of services that will be required over the course of the year or cannot determine when services will be required, it may instead award a contract through a prequalified services procurement process. The department defines in its request for qualifications the time frame in which services may be required and a plan selecting qualified bidders during this period.²³ Noncompetitive procurement is permitted if (1) there is an emergency, (2) the department determines, after a thorough investigation, that only one provider is qualified to perform the services, (3) a change in a contractor's administration, staffing, or facility has made it unable to perform the services, (4) a secondary purchaser wishes to purchase a portion of a program, or (5) the funding appropriation for the services specifically identifies a provider or type of provider. The department must keep on record a written justification for all noncompetitive contracts and must file a list of all such contracts with the Division of Purchased Services quarterly.²⁴

The terms of the contracts themselves are governed by the Code of Massachusetts Regulations 808.100: Prices, Reporting, and Auditing for Social Service Programs. A department may use two types of contracts: cost-reimbursement and fee-for-service. A cost-reimbursement contract includes a detailed budget specifying the total anticipated expenditure per line item, offsets per line item such as third-party payments or payments from other state departments, and the maximum amount DMH agrees to reimburse during the contract period. The contractor is reimbursed for costs documented and submitted to DMH each month and has a full year to reach the maximum. Cost reimbursement contracts may be used only if it is a start-up year, the program is available for purchase only by the department and utilization cannot be

predicted, or payment on a fee-for-service basis would be detrimental to the quality or effectiveness of the program.²⁵

Fee-for-service contracts include those purchased for negotiated prices, component pricing, or unit rate. There are two types of unit rate contracts: class rate and individual rate. Class rates, established by the state's Rate Setting Commission, are not discretionary. Historical expenditures of the providers of a specific type of service are examined and a form of weighted average is computed to set the rate per unit of service. These rates are reexamined every few years and after extended negotiations between the commission and the providers and a public hearing, new rates are set. DMH contracts for most outpatient services, psychiatric day treatment, and certain types of hospitalization in this manner. Individual rates occur if the service is different and meets a specific DMH need. The provider documents its projected costs and a special rate is negotiated. In general, residential programs fall into this rate category. In all cases, the Division of Purchased Services must approve the price to be paid under a contract and notify the state comptroller of the authorized price.

Contracts are monitored by requiring providers to submit a Uniform Financial Statement and Independent Auditor's Report to the Division of Purchased Services before the fifteenth day of the fifth month after the contractor's fiscal year has ended.²⁶ Providers are asked to submit the following audited basic financial statements: balance sheet, statement of revenues and expenses and changes in fund balances, and statement of functional expenses. They must also submit the following supplemental schedules: supplemental revenue, supplemental expense, supplemental employee, and supplemental program statistics.

Despite Massachusetts's elaborate array of regulations designed to encourage competition, some studies have found a lack of takers for mental health contracts. In a 1986 study, Schlesinger et al. found that almost two thirds of "competitively" bid contracts only attracted one vendor, and only 15 percent attracted more than two.²⁷ More recently, a Suffolk University study has argued that there is a lack of competition in the private sector with the implication that contracting out mental health services could actually raise costs to the state.²⁸ These results highlight the importance of understanding market structure for any evaluation of proposed reforms to contracting in mental health.

Rhode Island

Rhode Island covers approximately 1,500 square miles and has just over one million inhabitants (1990 estimate). The Division of Mental Health and Community Support Services (DMH), a subdivision of the Department of Mental Health, Retardation, and Hospitals, oversees the provision of community mental health services in Rhode Island. The planning emphasis is primarily on adults with a severe mental illness, whom the division terms "community support clients." The Rhode Island Department for Children and Their Families has the primary responsibility for the provision of mental health services to children.

The Rhode Island mental health service system is divided into eight catchment areas, each of which contains a single comprehensive community mental health center. The CMHC is a nonprofit agency that provides all the outpatient public mental health services in its area and is responsible for all admissions to and discharges from the Institute of Mental Health, the state inpatient facility. The service

system also includes three organizations that provide residential services to the severely mentally ill.²⁹ Contracts with these major providers totaled over \$24 million in fiscal 1991.³⁰

DMH also contracts with numerous small organizations for specific services; for example, in fiscal 1991, DMH funded a client literacy program, a refugee center, a mental health worker certification program, and others. The only non-CMHC contractor that provides services specifically aimed toward homeless mentally ill individuals falls into this category. Contracts with these small organizations totaled nearly \$3 million in 1991.³¹

It has been estimated that there are 4,400 homeless people in Rhode Island over the course of a year. A census done in April 1991 counted 471 individuals in shelters or visible on the streets; however, shelter operators report that the approximately 500 beds throughout the state are filled each night. DMH uses the following percentages to estimate the numbers of homeless mentally ill: 19 percent of all homeless individuals have a serious mental illness and an additional 27 percent are in need of mental health services.

In 1987, as part of the process of developing the state plan for mental health services, surveys of homeless individuals were conducted in Providence and Newport. The Providence survey was performed at eight sites (including shelters and the bus terminal) in addition to some street interviews. A total of 144 homeless people were interviewed. This survey found that 18.8 percent were judged to have severe and/or persistent mental disability.³²

The survey in Newport interviewed seven individuals looking for temporary shelter at a YMCA shelter. None of these were found to be "definitely severely mentally disabled." The results of this survey are not considered as valid as those of the Providence survey owing to the small sample size and lack of information on previous treatment.³³

As a result of these surveys, the mental health plan recommended the creation of aggressive outreach services focused on linking the homeless with mental illness with the necessary services; the plan states that the community support services it proposes were appropriate for these individuals and that the problem is more one of identifying and gaining service acceptance by this population. The plan proposed creation of the following programs: (1) an outreach and liaison program to operate on the streets, (2) a mobile care team to operate at shelters, soup kitchens, and similar sites, (3) drop-in center(s) located near homeless shelters, and (4) transitional residential beds.³⁴

Rhode Island funds four CMHCs to provide services specifically aimed at the homeless population. The services provided include homeless outreach teams and mobile treatment teams. Of the roughly \$300,000 allocated for services to the homeless, approximately \$200,000 is split among the four CMHCs. The remaining third funds a contract with a non-CMHC provider, Travelers Aid, which operates a drop-in center in Providence.

In an attempt to provide "light" services rather than the CMHCs' regular package of services, DMH funds the drop-in center, which is designed to be external to the CMHCs. Light services are social — having a cup of coffee together and talking. Because they are not structured, they are valuable in reaching individuals who are the most resistant to standard treatment, like many of the homeless population. The

drop-in center staff includes a full-time CMHC person to facilitate referral into the CMHC system, but referral is not the main focus of this service.

Contracts with community mental health centers result from sole source negotiations; there is no competition for these contracts. CMHCs must complete a plan for service development. This document defines DMH service priorities, standard program element definitions, planning guidelines, and service need data for each catchment area. CMHCs are required to prepare reports containing information on each of the program elements, which include the population served, service objectives and modalities, outcome assessment and quality assurance mechanisms, staff cost, units of service, and active clients and anticipated admissions and discharges in the previous year, current year, and as proposed for the coming year.³⁵ A separate budget application is prepared, which contains detailed expenditure and income data. Income data requested include income from federal grants, all state agencies, and local sources. Expenditure data include personnel and operating expenditure for each program as spent in the prior year, budgeted for the current year, and anticipated in the coming year.³⁶ The final contract amounts and service levels are negotiated between the contractor and DMH.

The contract with Travelers Aid for the drop-in center in Providence did go through a competitive process. Over two years ago, the division sent out an RFP for the provision of services of a more social, less treatment-oriented nature. CMHCs were not barred from competing for this contract even though the services requested were intended to get away from those of the standard CMHC package. Five proposals were submitted, three from CMHCs and two from other organizations.

Once awarded the contract, Travelers Aid became the sole source provider of these services and is annually re-funded in much the same manner as are the community mental health centers.

Each CMHC has one contract that covers the provision of all services. A non-CMHC contract, such as Travelers Aid's, is similar but would, of course, cover only the services specifically purchased from this provider. A general agreement contains general provisions; for example, equal employment opportunity requirements, termination and amendment terms, and language holding the state harmless from liability for any act of the contractor. Program descriptions and requirements are contained in addenda that cover broad categories of services such as community support services or acute alternatives. All program-specific information is found in these sections: the purpose of the service, the population to be served, and exact definitions of each service including how units of service are to be measured. Sections of the plan for service development that contain performance standards and targets which were agreed upon during contract negotiations are referenced and incorporated into the contract. Quality assurance and reporting requirements are included as well. Services to be provided to the homeless population, like mobile treatment teams, are contained in such an addendum.

A separate addendum defines the financial terms and conditions of the contract and includes a budget summary, payment terms, budget amendment procedures, and financial reporting requirements. Terms specific to service types may include required occupancy levels for residential services or penalties for overutilization of the state hospital for the mentally ill.

Provider performance is monitored by requiring periodic reporting of service and

financial data. Program reports must be submitted monthly. Required financial reports include the following: quarterly report of income and expenses, six-month income and expenditure detail, projection of year-end income and expenditure report, final expenditure report, and a year-end audit.

Vermont

The state of Vermont covers an area of approximately 9,600 square miles and has an estimated population (1990) of 563,000. The Division of Mental Health (DMH), an arm of the Department of Mental Health and Mental Retardation, has the responsibility for assuring the provision of mental health services to both children and adults.

The general service delivery system in Vermont consists of ten private, nonprofit community mental health centers, which are the designated providers of mental health services in the state; there is one CMHC in each of Vermont's ten catchment areas. The Division of Mental Health has contracts with these providers, but the contracts are not bid; instead, the CMHCs are annually re-funded. This service delivery system is not used to provide services specifically geared to the homeless mentally ill individual. It is, of course, true that all such individuals have access to the services offered by the CMHCs, but Vermont has decided not to give primary responsibility of reaching this population to the traditional service system.

This is similar to the situation in New Hampshire. The director of the Division of Mental Health and Developmental Services in that state has the authority to designate providers as "approved" for funding; the same ten CMHCs have been the approved providers since the 1970s. While in New Hampshire CMHCs are used to perform outreach and case management services, a large part of the services directed to the homeless mentally ill population is funded through contracts with local community action programs. These programs either supply housing themselves or monitor the availability of local housing. In addition, through a short-term cash infusion program, the division supplies funding that allows these programs to offer loans for initial rental costs like security deposits.

The Vermont Division of Mental Health estimates that there are approximately 1,200 homeless mentally ill individuals in the state. DMH funds all mental health services to the homeless through the federal PATH program. Vermont received \$300,000 from the program in fiscal 1991. State matching funds came from a variety of sources; for example, United Way, local municipal funds, state general funds, and volunteers. Only one organization received matching funds from the Division of Mental Health.³⁷

Due to the limited funds for services to the homeless, DMH has not attempted to create a statewide program but has targeted funds to areas where there are existing shelters or other homeless services programs. The policy is to tie the DMH program for homeless mentally ill individuals onto services that already attract these individuals. It is believed to be unlikely that a person involved with a community mental health center would become homeless, as services offered by all centers include housing subsidies (to cover the waiting period for Section 8 funds) and advocacy in addition to residential programs. Since people who are in the CMHC system are quickly housed, the majority of homeless individuals are those who are not using the CMHCs. In order to reach these individuals, the Division of Mental Health chose to contract with generic, antipoverty organizations not automatically associated with

mental health services. In the one case where services for the homeless are provided through a community mental health center, the services are provided at a drop-in center, not at the main office of the center.

The Division of Mental Health contracts with a variety of nonprofit organizations that provide services in six of the ten DMH catchment areas. The organizations include shelters, community action programs, a housing developer, and a consortium organization in Burlington that consists of a health center, a temporary shelter, and the community mental health center noted above.³⁸ The Division of Mental Health does not fund stand-alone programs but adds to existing ones. The type of organization that receives funding varies from location to location and depends on both the need for services and the existing providers. For the most part, DMH funds staff positions. For example, the division provides funds to shelters and community action programs to permit the hiring of an outreach person whose function is to identify and make initial contact with individuals exhibiting symptoms of mental illness. In Rutland, a neighborhood housing program, which provides assistance in locating housing, receives funds to identify individuals who need mental health services.

The services include outreach, case management, supportive counseling, assistance in locating housing and accessing housing benefits, advocacy, and referral; the emphasis is away from clinical treatment. The treatment philosophy is not necessarily to bring people into the traditional CMHC system. The services offered depend on the individual. If it makes sense to refer an individual to the standard system, this occurs. However, these people often have "fired" the CMHC. The intent is to reach the people who won't join the CMHC system.

The funding process begins when the DMH sends out notification of available funding. All existing contractors and other organizations that have expressed an interest in providing services geared toward individuals with mental illness are notified. In addition, there is an Advisory Board on Homelessness in Vermont whose members include shelter operators, representatives from churches, the Alliance of the Mentally Ill, mental health services consumers, legal aid providers, and community action program directors. This board is familiar with the organizations providing services to homeless individuals and can identify potential contractors. For the most part, however, the division has been working with the same core of providers since 1987, when the Mental Health Services to the Homeless block grant program began.

All organizations interested in receiving funding must submit an application and make a presentation to the advisory board. Organizations must specify both the services they propose and the budget necessary to provide them. The board annually reviews all submissions, then makes recommendations for funding to DMH. Funding is not automatically renewed; an existing contractor must submit an annual application and make a presentation regarding what has been accomplished in the current year and what is proposed for the following year.

Specific unit prices for services are not exogenously set but rather contract amounts are negotiated between the organization and the advisory board. The members of this board are involved in the provision and use of services and are therefore knowledgeable about the costs of services and the current pay scales. No outside state agency determines the pricing of contracted services. This is in contrast to Massachusetts, where two state agencies — the Rate Setting Commission and the

Division of Purchased Services — both outside the state mental agency, have jurisdiction over pricing.

Contractors are required to submit quarterly reports regarding changes in clients or services, staff training, coordination with other agencies serving the homeless mentally ill population, expenses by budget line item, and client contact data. The DMH program director reviews the quarterly reports and inquires about any changes in client or service numbers in an attempt to solve any problems that arise and as a way of monitoring changes in need which may necessitate changes in plans for the coming year. In addition, a team from the advisory board visits the contractors' sites and reviews their quarterly reports.

From the above description, we may draw some preliminary comparisons between the states' approaches to provider reimbursement and note possible policy implications.

First, states differ in their commitment to encouraging competition among bidders. For example, although Rhode Island selected the provider of its drop-in center by RFP, there are no plans to repeat the process in future years, effectively giving the winner an indefinite contract. By contrast, the winner of an equivalent contract in Massachusetts would be subject to a standard five-year RFP. This is in line with each state's wider approach to mental health contracting, in which Massachusetts appears to be more procompetitive.

However, it is also true that the use of RFPs can have anticompetitive effects in that the time and effort needed to respond may become a barrier to entry by small providers. In this respect, Massachusetts has higher barriers because it imposes considerably more paperwork and other requirements on bidders. Kramer and Grossman discuss this problem and note that states can reduce its impact by offering technical assistance to bidders, which Massachusetts does, or by actively helping recruit or establish new provider agencies.³⁹ Another argument sometimes made against the RFP process is that there are few providers in small states and the government already knows their costs and utilization, so that the process does not offer efficiency gains to offset the additional administrative costs.

A second observation is that the need to include nontraditional providers has a different impact on states' contracting policies, depending on their approach to bidding. Vermont and New Hampshire, which traditionally organize most of their contracting around CMHCs, had to expand their approach to include nontraditional providers. By contrast, Massachusetts was already committed to seeking multiple bids and using non-CMHC providers, so presumably contracting with homeless shelters would not have required major readjustments. However, this advantage appears to have been pursued only slightly, since the majority of programs aimed at providing services to the homeless mentally ill population in Massachusetts are not contracted but are operated by the department.

A third issue is the way the states deal with agencies that do not serve the homeless mentally ill exclusively. Examples are how to structure financing the CMHCs so that they treat some homeless and how to pay homeless shelters/agencies so that the mentally ill benefit from the funding. Rhode Island addresses the first of these by identifying, within the annual plan for service development, clients who are homeless or at risk of homelessness as a high-priority group. Necessary services such as housing, case management, and mobile treatment team are identified as well. With

respect to structuring contracts with homeless shelters, both Massachusetts and Vermont require that state funds be used to support staff with specific duties and responsibilities.

One reason to study states' varying provider reimbursement arrangements would be to see which approaches are best suited to helping as many homeless mentally ill as possible, as cost-effectively as possible. This study is necessarily less ambitious, since the health, housing, and cost outcomes associated with the different reimbursement arrangements were not analyzed. Rather, one can only draw more limited conclusions about how different contract designs are likely to affect the number of potential providers and the incentives facing them.

A conclusion is that existing contracting systems appear to reflect considerations other than procompetitive ones, for example, the desire to ensure continuity of care. This familiar problem in the human service sector confronts anyone attempting to introduce contracting approaches developed for other sectors with different market characteristics. Second, states appear to need contracting schemes flexible enough to accommodate non-CMHC providers in the case of the homeless mentally ill, even if their other mental health contracting is largely channeled through CMHCs. Finally, coordination among state agencies is crucial, given the complementarities among services needed by the homeless mentally ill; for example, funding special housing will help only if the state also ensures that social support services will be funded.

A more general conclusion is that this is clearly an area in which further research would be of benefit to policymakers. Like deinstitutionalization, contracting reform may be an idea whose details of implementation matter a great deal, and ignoring them could lead to undesired results. More work needs to be done to examine the conditions under which the homeless mentally ill will be helped by contracting out, and whether current and proposed reforms meet those conditions. The natural diversity of states' existing approaches may provide valuable lessons for future reform efforts. ❧

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Notes

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Streets Are for Nobody: Margaret Mullins

Sixties; single; former swimming instructor, Brookline; one of six children. Homeless twenty-two years; chronic drinker; died on the street late in 1989.

I grew up in the flats of Brookline with the cockroaches and the bedbugs. I'm the daughter of two Irish immigrants born and raised in Galway, Ireland.

I'm a complete virgin. I am a complete virgin. I've been harassed by punks, beaten by the police, and humiliated — a person of no existence. I've seen Eddie Fisher, Joni James, Debbie Reynolds, Johnny Mathis. I've been to Annapolis, West Point, Miami, the Breakers in Newport, Rhode Island. I've been to Niagara Falls — I've been all over. I met all types of celebrities in my life — I was an extremely sophisticated woman. Now I'm dealing with nonexistent humanitar — I don't know what they are. I've pimped for a quarter. I'm . . . I'm . . . I'm approached by pimps . . . day in and day out. I knew the Combat Zone [a Boston bar] in 1942 'cause I traveled with the biggest gangsters in Boston.

Skid Road is always bad — no matter where you are. But people are educated to a nonexistence. They come out of college with a "depleted" mind. I've ate in the best restaurants in the United States. My shoes were custom made in Beacon Hill. My clothes were . . . tailor made in Filene's upstairs and not in the basement . . . upstairs. My hair was done twice a wee — I taught preschool nursery. I taught all ages of swimming. And I lost my pension by six months.

I was at Mass Mental, uh, three times, and then they had me committed to a private psychiatric hospital. (Whisper: You had a breakdown?) Yeah, I had three breakdowns for the pills and the booze. They put me on medication because I was manic-depressive. But, AA [sigh], AA is more approachable to me than psychiatric help. I think I need both. I think that I need psychiatric help — not that I'm retarded or that I have an IQ of a mongoloid, but my approach to society is very difficult. I'm not retarded and I'm not a genius — I didn't develop electricity. I have an inqui . . . inquisitive mind and I would like to go in more and more into history. And I get frustrated and I try to contact my sisters — my younger sister's very worried about me — about my emotional problems. She knows that when I'm not learning, how emotional I can get.

I usually read the, um, business page — I studied investments at Harvard at night, and I went to Stone and Webster and I took an investment course there. I wanna get back to Brookline so I can go back to school and study speedwriting, investments,

Interviewed by Melissa Shook, February 1989, Long Island Shelter. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

and speed reading. I . . . I've taken efficiency reading. When I got to the island [Long Island Shelter], I spent all my time reading. 'Bout different things and research my teeth. (Whisper: They're gonzo). My glasses are gone. But I read all the time. Occasionally, I will go and read about women and the styles of women's . . . my hair, you know, and my makeup is gone, but I'm not gonna wear makeup anymore, but . . . my teeth — have to fix my teeth up. I got beaten up by the police. Police broke my tooth and hit me in the leg, long time ago. Do you believe in Saint Jude? He's the saint of hopeless cases.

[Once, at a shelter, she ran into a woman working as a counselor who had also been an inmate in Framingham State Prison.]

I walked in one night. I was sleepin' out on the streets for . . . oh . . . I was terrible that night — oh, my God. My hair hadn't been washed for months — my — I was so dirty, I had . . . gone all bathroom all over myself. My God, I was terrible shape that night. And I walked in and I saw this girl and I didn't know who she was and there was a police officer there. I keep looking at her and looking at her, you know. Without my glasses, I can't see. Finally, I remembered her — we were real baddies together up there. She was on the drugs, you know. Finally, I remembered her. I tapped her on the shoulder and she looked at me and says, "Jesus Christ, who is that bitch?" I tapped her again and she looked at me and then she remembered and and she went, "Aoooh, Margaret," and oh, I was so dirty, my God, I hadn't taken a bath for months. (Whisper: I musta smelled shit from head to foot.) And she started huggin' me and kissin' me. And the cop was lookin' at it and everybody was lookin' at it. And she was huggin' me and she said, "Is this where you are?" I says, "Yuh." And she said, "I gotta get you washed up, Honey, you look terrible." I said, "I know, I'm in tough shape." And nobody knew it.

And then I said, "The dignity in that woman and she doesn't even know what's in my heart, what's in my soul."

All streets are the same. Can be in New Bedford, in Fall River, could be in Worcester, could be Springfield, the South End, you can be in San Francisco, you can be in New York. Man I'm dealing with, jeez, I've seen them die in the bar of New York. All streets are the same — South Boston streets, East Boston streets, North End streets.

All streets are the same, but you don't get to the streets by yourself. There's a few people that help you get there. Somerville streets, Cambridge streets. I told Freddy today, "Listen to me, Freddy, I'm old, I'm way aheada you. It's very hard to get off the streets. Once you are on 'em, you can stay on 'em or you can get off them."

He says, "Margaret . . ." I says, "You better get off these streets, Freddy. Streets are for nobody. They're nothin' but crime, murder, and misery. You can laugh at them now, but tomorrow, you won't laugh at them. Streets are the streets. No matter where you are." ❧

Homelessness in Massachusetts

Perception, Policy, and Progress

Milton Argeriou, Ph.D.

Homelessness is not a new phenomenon in Massachusetts, nor are the “new” homeless of the 1980s and 1990s that different from the “old” homeless of previous decades. What is new is the societal response to the burgeoning population of homeless men, women, and children. Massachusetts’s response to the problem of homelessness in the 1980s, as outlined in the Massachusetts Comprehensive Policy Approach, is examined and found to reflect commitment and creativity. However, the problem of homelessness in Massachusetts remains, the community appears frustrated, and current budget cutbacks do not augur well for future services to the homeless.

Homelessness in Massachusetts is not a new phenomenon. Henry Miller reports that as early as 1675, sixty-two refugees from the uprising of Indians in Rhode Island, arrived in Boston, “became public charges, and had to be ‘warned away’ and removed.”¹ The response of the early settlers to these homeless individuals reflects the traditional, though disguised and denied, societal perception of the homeless as “troubled and troublesome individuals.”² Attributing the cause of homelessness to the deficiencies of the homeless themselves has long provided balm for the social conscience and, more important, justified public policies that did not address the larger social and economic roots of homelessness.³

Beginning in the early 1980s, however, the perception of the homeless began to change, largely as a result of human interest stories prepared by reporters and analysts in the course of their documentation of the effects of the 1981–1982 economic recession.⁴ In contrast to the undeserving homeless of the past, the “new” homeless were depicted as victims of forces beyond their control; “Homelessness was presented not as an individual problem with bad social consequences, but as a social problem that overwhelms individuals.”⁵ The homeless of the 1980s and 1990s are indeed different from the stereotypical homeless of preceding decades. The “new” homeless are younger, better educated, heavily populated with racial and ethnic minorities, and marked by higher rates of drug abuse.⁶ They are also distinguished by the presence of a variety of subgroups, including large numbers of women,

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women with children, entire family groups, adolescents, veterans, and people with the dual diagnosis of substance abuse and mental illness.⁷

Despite these outward differences, the new homeless resemble the old homeless in many ways. For example, alcohol and drug abuse continues to play a significant role in the lives of homeless men, women, adolescents, and even children. In fact, alcohol and drug abuse is considered to be the most prevalent health problem among today's homeless.⁸ According to James Wright, compared to nonabusing homeless, those who abuse alcohol or drugs "are generally in the worst possible shape, more estranged, less intact, sicker and with the poorest prospects for the future."⁹ Prevalence estimates of alcohol and drug abuse among the homeless vary, depending on the sample, definition of homelessness, setting (for example, street versus shelter), the methods, and the assessment tools. Pam Fischer's exhaustive analysis of prevalence estimates published in "technically sound" studies during the 1980–1990 decade revealed rates varying from 8 to 68 percent for alcohol problems, and 10 to 20 percent for drug problems among homeless men and women.¹⁰ Prevalence estimates derived from the Robert Wood Johnson Health Care for the Homeless Demonstration Projects showed approximately 38 percent of those serviced by the projects had alcohol problems, and approximately 13 percent exhibited drug-abuse problems.¹¹

In addition to high rates of alcohol and drug abuse, other continuities between the old and the new homeless include high levels of mental illness, physical disability, criminality, and similar patterns of social isolation. The new homeless, as the old, are comprised of the most vulnerable of our society.¹²

In the rush to respond to the problems of the new and deserving homeless, the resemblance of the new to the old, and the intransigence and complexity of their problems, may not have been fully appreciated by even the most informed. It was assumed that with the application of sufficient and appropriate resources, the problem of homelessness could be resolved. Charles Hoch and Robert Slayton argue that this approach is misguided and fails to consider the major underlying causes of homelessness.

Thus, the contemporary homeless are not a new kind of social group, but members of the single working poor victimized by urban policies that encourage the destruction of SROs (single room occupancies) and other types of low-income housing, changes in the national economy that increase unemployment and underemployment among the independent poor, and welfare policies that undermine the social autonomy of the dependent poor. A politics of compassion that identifies the vulnerabilities of the homeless as the cause of their predicament too easily overlooks the social and economic history of the urban working poor and their struggle for affordable shelter.¹³

While Hoch and Slayton may be correct, it remains that federal, state, and local governments were faced with the immediate need to respond to the burgeoning population of homeless men, women, and children. This article examines the Massachusetts response and attempts to assess its impact on the problem of homelessness in Massachusetts.

Massachusetts Homelessness Policy

The Massachusetts Comprehensive Policy Approach to Homelessness was the Michael Dukakis administration's response to the problem of homelessness.¹⁴ The

four-part strategy included prevention, emergency services, supportive services, and permanent housing. It was based on a causal model of homelessness that included "a shrinking supply of affordable housing, poverty, domestic violence, alcohol and drug abuse, mental illness, family turmoil."¹⁵

Prevention of homelessness was the focus of landmark legislation passed in 1983, MGL Chapter 450: An Act to Prevent Destitution and Homelessness. The act removed the need to have an address to be eligible for state entitlement benefits such as AFDC, General Relief, and food stamps. Other strategies included emergency assistance, information and referral, housing services to prevent eviction, rent and utility payment, fuel assistance, and advocacy. Emergency services provided shelter, food, clothing, and financial assistance. Supportive services included outreach, day care, alcoholism programs, health care, twenty-four-hour crisis services, Medicaid/Medicare programs, housing counseling, and employment counseling. The fourth part of the strategy involved programs to stabilize homeless individuals and families by developing and providing housing, employment, and supportive services. A critical element in the provision of services and supports outlined in these four areas was the addition of a case management component operated to "guide the individual through the homeless crisis to appropriate services and housing," and prevent them from falling "through the cracks" and back into the homeless cycle. Taken together, the Massachusetts plan appeared to contain the ingredients necessary to reduce homelessness.

We are approaching the seventh anniversary of the implementation of the plan, and it is appropriate that we make an effort to assess its impact on the problem of homelessness in Massachusetts. Accordingly, I shall examine each of the four areas addressed by the plan, and attempt to assess progress achieved by examining a variety of indicators of homelessness, and concrete actions taken to reduce homelessness.

Prevention

Presumably, if prevention efforts are effective, the number of homeless individuals and families should decrease, or at least not increase, over time. While enumeration may be an imprecise and an indirect measure of prevention effectiveness,¹⁶ it is instructive to examine available "counts" of the homeless. Enumeration of the homeless in the larger metropolitan cities began in the early 1980s.¹⁷ Boston, one of the first cities to conduct a "one-night" count of the homeless, has carried out this one-night census six times since the first count was made on October 27, 1983. Table 1 presents the results of these enumeration efforts.

While there is considerable variation in the numbers of homeless over time, there is little basis to conclude that the size of the homeless population in Boston is decreasing. However, the possibility exists that the observed increase may be somewhat artifactual in nature. For example, there is some evidence to support the contention that Boston has become "a 'mecca' for the homeless."¹⁸ Boston has had an open-door policy regarding the homeless and exhibited the willingness to increase emergency shelter beds to accommodate demand. This being so, the increase in the number of homeless shown in Table 1 may represent migration to Boston of existent homeless rather than an increase in the absolute number of homeless individuals.

The demand for emergency shelter is another indicator of the number of homeless and whether this number is increasing or decreasing. Since supply is a reflection of demand, an examination of the number of shelter beds available provides another

indication of the number of individuals needing shelter. Based on these data, there is little doubt that the number of individuals seeking shelter has increased dramatically in a brief period of time. In 1983, there were two state-funded shelters in Massachusetts.¹⁹ Today the one hundred shelters supported by the Department of Public Welfare includes twenty-eight individual shelters and seventy-two family shelters. Shelters for individuals are generally larger than family shelters in terms of bed capacity. Overall, approximately twenty-five hundred beds are available in these hundred shelters.²⁰

Table 1

Boston Census of the Homeless 1983-1990

	1983	1986	1987	1988	1989	1990
Males	2,056	1,861	2,198	2,150	2,289	2,406
Females	573	687	768	782	985	771
Children (under 17)	138	315	525	521	556	436
Totals	2,767 ^a	2,863 ^b	3,491 ^c	3,453 ^c	3,830 ^d	3,613 ^e

Sources:

^aCity of Boston, Emergency Shelter Commission, *The October Project: Seeing the Obvious Problem* (Boston: Emergency Shelter Commission, 1983).

^bRaymond L. Flynn, *Making Room: Comprehensive Policy for the Homeless* (Boston: City of Boston, 1986).

^cEmergency Shelter Commission, *City of Boston Homeless Population Census Winter 1988-89* (Boston: City of Boston, 1989).

^dEmergency Shelter Commission, *State of Homelessness in the City of Boston Winter 1989-90* (Boston: City of Boston, 1990).

^eEmergency Shelter Commission, *State of Homelessness in the City of Boston Winter 1990-91* (Boston: City of Boston, 1991).

In addition to shelters supported by the Department of Public Welfare, 153 transitional shelter beds are also provided in four psychiatric shelters supported by the Department of Mental Health, and an unknown number of additional beds are provided in an estimated thirty to forty other facilities supported by private funds. Figure 1 presents a graphic depiction of the growth in the number of shelter beds in Boston from 1983 to 1991.²¹ Because approximately two thirds of the shelter beds in the state are located in the Boston area, the Boston data illustrate the growth of shelter beds statewide.

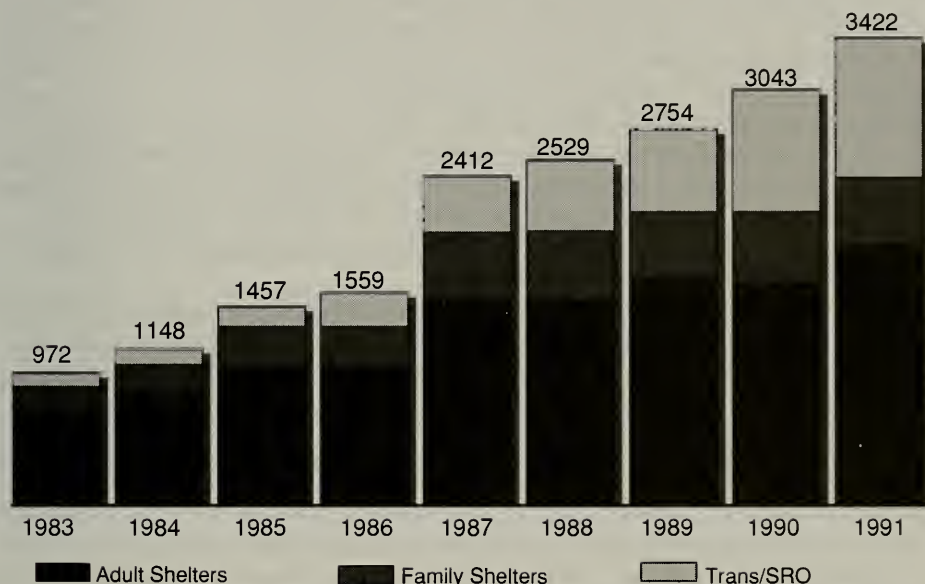
Does this increase in the number of homeless men, women, and children and the demand for shelter mean that prevention efforts have been entirely unsuccessful? The answer is most likely no. It is quite possible that the observed increases would be even higher without efforts to prevent homelessness. According to Massachusetts officials' reporting in 1986, prevention efforts had already provided \$32 million to thousands of families to assist them to pay back rent and utility costs and avoid eviction. Another prevention effort involved mediation of landlord/tenant disputes, which involved 12,100 tenants and 7,600 landlords in the first eighteen months of the Housing Services Program begun in 1985. Other efforts included increases in AFDC payments, development of a model housing and employment program for AFDC recipients, modification of discharge policies to prohibit discharging the mentally ill

to the streets and shelters, and enactment of condominium conversion legislation, which "protects low-income and other vulnerable tenants from eviction."²²

It remains, however, with the exception of efforts to preserve SROs, that many of the prevention efforts described in the Comprehensive Policy Approach to Homelessness are stopgap in nature, responding to immediate crisis situations of specific individuals and families. Such assistance may delay eviction, provide clothing, pay utilities, and so forth, over the short term, but are unlikely to prevent the inevitable loss of housing over the long term. To be truly preventative, efforts need to be expanded to encompass the larger underlying causes of the homeless, which are societal, not personal.

Figure 1

Shelter Beds in Boston



Source: Raymond L. Flynn, *Commitment and Compassion: Boston's Comprehensive Policy for the Homeless — Winter 1990-91* (Boston: City of Boston, 1991), 6.

Emergency Services

The data presented in Figure 1 highlight the commitment of Massachusetts to ameliorate the plight of the homeless and ensure the availability of shelter and food. Most noticeable, however, is the linear increase in the number of shelter beds. Elsewhere, the experience is similar.

In January of 1983, New York City sheltered 4,676 men and 636 women in 18 shelter facilities, but four years later, the numbers had jumped to 9,000 men and 1,100 women in 18 facilities . . . In Chicago, the number of emergency beds skyrocketed from approximately 700 beds in November 1982 (none of which were specifically designated for the homeless) to more than 2,000 beds in 1986.²³

Of particular concern to some observers is the growth of what they term the "shelter industry" and the institutionalization of what began as an emergency response to a crisis situation.²⁴

The provision of temporary accommodations has usually given the homeless important benefits that they could not have obtained otherwise. The very success of these efforts, however, now threatens to transform short-term shelter facilities into long-term caretaking institutions, as officials and caretakers build full-service shelter facilities that simultaneously segregate and rank the homeless and organize their treatment. Classifying the homeless as a special population marked by peculiar vulnerabilities, however, not only perversely sets them apart from other citizens, but relegates them to the inferior status of worthy dependents.²⁵

The concern that the condition of homelessness not be institutionalized is well taken. So, too, is the concern that shelters not be considered an adequate response to the problem of homelessness. Moreover, the manifest function of providing shelter does carry with it the latent function potential of establishing shelter living as a way of life.²⁶ But these concerns should not obscure the positive changes occurring in shelters and the use of shelters as service agencies.

These changes appear to be related to the frustration of shelter providers associated with the futility of providing a "hot and a cot" to growing numbers of individuals on an indefinite basis. Conversely, the changes are related to the desire of shelter providers and other public health workers to seize the outreach and intervention potential inherent in shelter settings. Accordingly, many of the larger shelters have established a variety of programs within them.

One of the earliest programs was the introduction of health care services in shelters in conjunction with the Robert Wood Johnson Foundation grant. Boston was one of nineteen cities selected by the foundation to develop such services. Over twenty thousand homeless men, women, and children have been treated since the Health Care for the Homeless program began in July 1985.

Health Care for the Homeless also developed an innovative respite program at the Shattuck Shelter in Jamaica Plain.

The respite unit provides recovery care for homeless individuals who are not well enough to walk outside each day but who do not require admission to a hospital. Established in 1985, this program offers comprehensive medical, nursing, social and psychiatric care for up to 25 homeless patients who are unable or reluctant to follow routine treatment plans. It is a cost effective program which provides a less expensive alternative to inpatient hospital care for individuals who are recovering from treatment. The average length of stay in the respite is 17 to 20 days.²⁷

Another major effort has been the development of substance-abuse programming in shelter settings. Its effectiveness is illustrated in encouraging results from the Stabilization Services Project, a three-year community demonstration project funded by the National Institute of Alcohol Abuse and Alcoholism under Section 613 of the Stewart B. McKinney Homeless Assistance Act. In contrast to general expectations that large shelters with many guests who are actively drinking and using drugs would be too unstructured and complex to be conducive to the development of effective recovery programs, almost two thirds of the clients assigned to stabilization programs in shelter settings maintained their sobriety and completed the program. Upward of 60 percent of the clients assigned to the Shattuck Shelter and the Long Island Shel-

ter completed a transitional period of postdetoxification residential programming (stabilization) averaging thirty-four days.²⁸

In addition to the programs at the Shattuck and Long Island shelters, the Massachusetts Bureau of Substance Abuse Services supports a similar program at the Plowshares Shelter in Topsfield and substance-abuse programming at selected family shelters located across the state. The use of shelter settings for substance-abuse programming has become accepted practice in a brief period of time. Such utilization of shelters makes sense programmatically, logistically, and economically, and reflects the changing use of shelters as interventions in the lives of homeless individuals rather than temporary places to sleep.

Supportive Services

The inclusion of supportive services as part of the comprehensive plan to combat homelessness reflects the recognition that "homeless people need more than a roof over their heads as they move from the crisis of homelessness to a more stable situation."²⁹ Support services were seen as the "glue" that would tie the four parts of the plan together. One of the first supports to be developed was Family Action Support Teams (FAST) to assist families to gain access to needed services — for example employment/training, transportation, day care, counseling, health care — and to find permanent housing.³⁰ An interagency team approach involving the Departments of Mental Health, Public Health, and Social Services under the direction of the Executive Office of Human Services was used to carry out the development of supportive services.

Most recently, as indicated earlier, alcohol programming has been introduced in large individual shelters, and substance-abuse family shelters have come on line. But with all the positive gains over the past seven years, support services, particularly case management services, have not been fully developed or evenly distributed across shelter types. "Unlike the family shelters, which offer housing search assistance, family life advocate on staff, and other outreach services, the individuals receive virtually no counseling and services except for Health Care for the Homeless teams or Veteran's Outreach counselors."³¹ This assessment by the former secretary of Human Services in the spring of 1990 of the status of support services for the homeless in Massachusetts clearly indicates that considerable additional effort would be required to fully implement the Massachusetts plan to combat homelessness.

Permanent Housing

The commitment of over a billion dollars in housing bond authorizations to develop affordable housing established Massachusetts as a national leader. Massachusetts has also been creative in establishing a variety of programs to service special-needs people. One of these, the 707 Rental Assistance Program, has been used to develop single-room occupancies (SROs) for homeless individuals in recovery from substance abuse. The rental certificates are assigned through local housing authorities to designated nonprofit agencies which use these certificates as guaranteed income (collateral) to borrow the capital necessary to develop the SROs. The Paul Sullivan Trust has developed the largest number of such units using this model. Currently, the trust operates eleven lodging houses with 185 units. All houses include resident managers and external staff who provide support services. All residents have a history of homelessness, and many report histories of substance abuse and/or mental illness. Two other 707-funded special housing projects include the Moultenbray House (24 units)

in Turner Falls, the Easler Building (12 units) in Gloucester, and houses in Hudson and Framingham operated by the South Middlesex Opportunity Council.

A variety of other housing programs have been developed which impact the homeless and near homeless. The Special Needs Housing Program (Chapter 689) is devoted to new construction to house the mentally ill and developmentally disabled people, substance abusers, adolescents, pregnant and parenting teens, and people with physical disabilities. More than \$100 million was committed to this program between 1983 and 1988.³² The Housing Innovations Fund is also designed to attract and direct developers to create housing for special-needs people. Other state programs for low- and moderate-income people include State Housing Assistance for Rental Production (SHARP), Tax Exempt Local Loans to Encourage Rental Housing (TELLER), and the Homeownership Opportunity Program.³³ These data illustrate the commitment of the state to ensure permanent housing for homeless, special-needs, and low- and moderate-income people.

Despite these state efforts, and other housing programs funded by federal dollars through the Stewart B. McKinney Act and the Department of Housing and Urban Development (for example, Section 8, Section 202, Title V), the need for permanent housing remains. Such need is demonstrated not only by the individuals and families residing in public shelters, but also by a two-year waiting period for existing public housing units.

The Future

The Number of Homeless and the Demand for Services

The decline of homelessness in Massachusetts in the immediate future appears unlikely. Recovery from the 1990–1991 recession is projected to take longer than expected, and the recovery, when it comes, is likely to be to a level lower than hoped for. Because homelessness is inextricably tied to the vicissitudes of the national and regional economies, it is unlikely that any sizable reduction in the number of homeless will occur until economic recovery occurs. Other factors that will sustain, and perhaps even increase, the demand for shelter include cutbacks in state funding of existing programs, failure to develop new programs (particularly housing resources), and increases in substance abuse (especially cocaine and crack addiction).

Perception of the Homeless

There are indications that the politics of compassion have become burdensome and that an “exhaustion of sympathy,” or as Loni Hancock, mayor of Berkeley, California, calls it, “compassion fatigue,” may be occurring among the more fortunate members of American society.³⁴ Evidence of this change in public attitude toward the homeless is seen in responses of city officials, service providers, and other informed community representatives to questions contained in the U.S. Conference of Mayors Task Force on Hunger and Homelessness Information Questionnaire.³⁵

Specifically, informants in thirty cities were asked, “During the last year, have you seen any evidence that public sentiment toward homeless persons is changing?”³⁶ Respondents in six cities indicated no change in public attitude, three cities saw positive change, eight cities saw both positive and negative changes, and most important, thirteen cities saw only negative changes occurring. Some of the comments derived from these thirteen cities mentioned the intractability of the problem, the desire to move on

to other resolvable issues, and concern with violence associated with homeless individuals. Some cities pointed to "the increasing tendency to blame the homeless for being homeless," and to stigmatize them in a manner reminiscent of earlier times.

It is of particular interest that Boston was one of the thirteen cities which indicated a negative change in public attitudes toward the homeless. "People have become increasingly concerned with the number of homeless mentally ill persons on the streets. They are also commenting on the apparent increase in panhandlers on the street who, while not necessarily homeless, appear as if they are."³⁷

Whether this assessment of public attitudes toward the homeless in Boston is accurate is questionable. Based on the positive response of the public to fund-raising efforts by the Friends of the Shattuck Shelter and the Friends of the Long Island Shelter, the "compassion fatigue" factor in Boston would appear to be low. Clearly, other data are necessary before conclusions about public attitudes can be made.

Programming

Public attitudes aside, erosion in benefits and programs directly affecting homeless individuals has recently taken place, attributable to state revenue shortfalls and the need to reduce expenditures. A brief review of some of the cuts experienced by the Department of Public Health's Bureau of Substance Abuse Services, the Executive Office of Communities and Development, and the Department of Public Welfare, illustrates the nature and magnitude of the loss of service.

Substance-Abuse Services. The Bureau of Substance Abuse Services contracts with over 230 community-based agencies for the provision of alcoholism and drug-abuse prevention and treatment services. While these services are available to all residents of the commonwealth, for the indigent and homeless, publicly supported services represent the only substance-abuse treatment services available to them. Consequently, any reductions in the operating budget of the Bureau of Substance Abuse Services automatically has an impact on the homeless and near homeless substance abusers who comprised approximately 18 percent of the 92,000 admissions in fiscal year 1990 to the substance-abuse treatment services supported by the bureau.

State funding for alcoholism and drug-abuse prevention and treatment has declined 30 percent from \$40 million in fiscal 1990 to \$28 million in fiscal 1992. A decrease of this magnitude requires restructuring and setting priorities of services provided. Since the two most costly services — detoxification centers and recovery homes — are also the two services most heavily utilized by the homeless substance abuser, it is clear that efforts to restructure and streamline these services will affect this population most heavily.

Compounding service reductions caused by cuts in the Substance Abuse Services budget, cuts in the budget of the Department of Public Welfare (DPW) will affect DPW coverage of addiction-treatment services for individuals receiving General Relief. Effective August 21, 1991, payments for detoxification, outpatient, and acupuncture services provided to recipients of General Relief were eliminated. As of December 31, 1991, payment for these services was restored to individuals who received emergency assistance benefits. The overall effect, however, was to reduce sharply the number of individuals eligible to receive these services.

Housing Services. The Executive Office of Communities and Development (EOCD) was established under the Dukakis administration as a cabinet level agency with primary responsibility for developing affordable housing. Most state-funded

housing programs designed to have an impact on homelessness are under the direction of EOCD. Table 2 shows the major reductions in housing programs support caused by fiscal 1992 EOCD budget cuts.

It is not possible within the scope of this article to explore all ramifications of the budget reductions shown in Table 2. However, given the magnitude of the reductions, particularly for 707 rental assistance, housing services, and supportive services, it is clear that housing assistance to the homeless, near homeless, and low-income families has been severely affected. The loss of 707 funding will require recipients to increase their share of the rent, reduce administrative fees paid to housing authorities and regional nonprofits from \$45 to \$15, and preclude expansion of 707 assistance. The reduction in housing services dollars and the failure to fund supportive services essentially eliminates one of the four components of the Comprehensive Policy on Homelessness described earlier. For homeless individuals and families needing assistance to negotiate the bureaucracy associated with publicly supported housing, the loss of supportive services may effectively preclude them from obtaining such housing, even if it were available.

Table 2

Final Fiscal Year 1992 Housing Budget

Housing Program	FY91	Final FY92 Budget
SHARP		
State Housing Assistance for Rental Production	\$31.4m	\$31.4m
RHDAL		
Rental Housing Development Action Loan	\$2.18m	\$2.498m
Chapter 707 Rental Assistance	\$110m	\$77m
Public Housing Operating Subsidies	\$28m	\$22.4m
CEED		
Community Economic Enterprise Program	\$753,120	\$750,000
Housing Services	\$564,480	\$300,000
Supportive Services	\$4.3m	\$0
HOP		
Homeownership Opportunity Program	\$2.42m	\$0

Source: *Summary of the Final FY 92 State Housing Budget* (Boston: Citizens Housing and Planning Association, 1991), 3.

Welfare Services. Homeless and near homeless individuals and families are most directly affected by cuts in the Department of Public Welfare (DPW) budget for Emergency Assistance (EA) and General Relief. "Emergency Assistance is a program to help families avoid homelessness, and to help homeless families secure a place to live . . . General Relief is an income assistance program for individuals who are unemployable by reason of disability or lack of training/education/experience."³⁸ Taken together, the reduction/elimination/suspension of funding for these two programs is likely to increase significantly the demand for shelter services, particularly by women with and without children.

More specifically, as of August 1, 1991, the following EA benefits were suspended for one year:

- First month's rent and security deposits for homeless and at-risk homeless families
- Moving and furniture storage fees
- Transportation, child care, and nutrition allowances for homeless families
- Relocation benefits for disaster victims³⁹

The loss of these benefits essentially eliminates the capability to move families out of shelters. Other planned budget cuts would eliminate the EA Arrearage Program, which prevents homelessness by paying back rent and utility and fuel bills (up to three months) for poor families. According to the Massachusetts Coalition for the Homeless, 84 percent of the forty thousand families that used EA benefits in 1990 did so to prevent homelessness.⁴⁰ Loss of EA benefits, therefore, removes the only safety net strung beneath the lives of poor families in Massachusetts.

The loss of General Relief (GR) benefits is wide ranging and also carries a significant potential for increasing the ranks of the homeless. For example, the denial of benefits to individuals over age forty-five with little or no work history eliminates the only source of income for thousands of men and women. Other GR cuts include the elimination of Emergency Relief, "a homeless prevention program patterned on the Emergency Assistance Program",⁴¹ the elimination of Employment Training Program, clothing allowances, family reunification benefits, fuel assistance, and major reductions in the GR medical program.

It is interesting to note that this is not the first time GR benefits have been curtailed in response to a fiscal crisis. In 1975, GR was "changed from a needs-based program to one whereby applicants must prove not only financial need, but must fit into a category of eligibility as well."⁴² This change resulted in the loss of assistance for approximately eighteen thousand individuals.

Ironically, funding for the provision of emergency shelter services has remained intact. However, such services are likely to be severely strained as the homeless and near homeless enter the winter season without DPW assistance programs. The experience of Massachusetts in the coming months will provide valuable comparative data regarding the impact of public policies on the problem of homelessness. Careful monitoring and documentation of this experience should be carried out to ensure that these data and the lessons learned are not lost.

Shelter Size

It is unlikely that Massachusetts will witness the development of large shelters in the future. Concern about health and safety issues in some of the larger existing shelters has resulted in official recommendations to "begin to phase out larger shelters in favor of smaller community based shelters and transitional housing programs."⁴³ Small intimate shelters have always been preferred over larger impersonal shelters in the eyes of Massachusetts planners.⁴⁴ Despite such recommendations, it is unlikely that the existing large shelters will disappear.

Large shelters have strong advocates who are unlikely to dismantle services considered critical to homeless individuals. Large shelters are also major service providers to homeless substance abusers whose addiction, physical condition, and social deficits make them unlikely, and probably unwanted, candidates for small intimate community-based shelters. The location of the large shelters, efficiency of operation, and laissez-

faire policy make them "attractive" to homeless substance abusers unable to manage their addictions and to large segments of the public who do not want this population in their backyards. This convergence of political, practical, and personal interests may well operate to promote continuance of large shelter operations.

Shelter Functions

The functions of shelters, particularly large ones, have expanded in number and scope in the past eight years. Beginning with the early introduction of medical and respite services provided by the Robert Wood Johnson Health Care for the Homeless Project, services may now include substance-abuse programming, health education (including AIDS education and prevention), employment training, life-skills training, work programs, "holding" individuals in transit between substance-abuse service providers, and transitional housing. It is unlikely that such programming, once initiated, will not continue to operate, and even expand, in the future. Russell Schutt, who has extensively studied the problem of homelessness and the shelter system in Massachusetts, sees some shelters as "likely to serve as new, innovative models for meeting social service needs well into the 21st century."⁴⁵

Shelters can be perceived as "windows of opportunity" to outreach and intervene in the lives of the homeless, particularly the substance abusers. Instead of bringing the client to the service, services are being brought to the client. In Massachusetts, ongoing experimentation with the form and function of shelters reflects the commitment of shelter providers and state officials to exploit the potential of shelters as service agencies.⁴⁶

The productive use of shelters as stable service agencies rather than temporary emergency facilities reflects the recognition that the problem of homelessness is long term and unlikely to disappear in the near future. This is particularly true for the substance abusers whose problems are exacerbated by their homelessness, and vice versa.

It is in response to this latter group of homeless that we may ultimately see the functions of shelters expanded to include social model detoxification.⁴⁷ For all practical purposes, such detoxification routinely takes place in shelters as intoxicated guests are allowed to "sleep it off." Given the continuing prospect of further reductions in state funding of substance-abuse services, the development of lower-cost nonmedical (social) model detoxification services may be required.

Double Standard

Caution will need to be exercised to ensure that services for homeless persons do not develop into a two-tiered system in which the "new deserving homeless" are treated differently from the "old undeserving homeless." As Madeline Stoner states,

By making this distinction (between the old and the new homeless) some of the newly developed services and legislation designed to aid homeless people have reflected the ancient Elizabethan division between the able bodied poor and the impotent poor. It is important to note that the "chronic homeless" were once new.⁴⁸

An indication that some differential allocation of resources may already have occurred in Massachusetts is the lack of counseling and case management in "individual" shelters, as compared to family shelters, noted by former secretary of

Human Services Philip Johnston.⁴⁹ In defense of the differential allocation of scarce resources, one can point to data that show a higher probability for certain subgroups of the homeless to move out of the state of homelessness more quickly than others.⁵⁰ Such data may support the proponents of economic expediency, but fail to resolve the issue of moral imperatives.

The French expression “plus ça change, plus c’est la même chose” (the more things change, the more they are the same) seems particularly applicable vis-à-vis the homeless. The “new” homeless are not unlike the “old” homeless. What is new is the societal response to the problem. But as we have seen, even that may be changing.

Massachusetts, in general, appears to have done a creditable job in responding to its homeless men, women, and children. There are, however, indications that some of the gains made over the past years may be lost because of the state budget crisis. Mitigating these losses will require new and perhaps unconventional strategies.

An example of such a strategy, taken from the field of substance abuse, is the phenomenal growth and impact of self-supported, self-run, long-term housing for recovering substance abusers known as Oxford Houses.⁵¹ In the brief span of approximately two years, over 250 Oxford Houses have been established across the country using \$100,000 revolving loan funds established in each state, as mandated by the 1988 Anti-Drug Abuse Act. Fourteen Oxford Houses have already been established in Massachusetts. The Oxford strategy is simple, efficient, and most important, highly cost effective.

Another strategy is the approach taken by the Plowshares Shelter in Topsfield, Massachusetts, which intends to train and prepare its guests for social reentry. The final program step will be the acquisition of a loan from the state revolving loan fund to establish an Oxford-style residence for program graduates.

These strategies reflect the breaking of “set” and the willingness to experiment with the unknown. They represent the kind of effort and ingenuity that will be required to respond to the continuing problem of homelessness in Massachusetts. 🐾

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Notes

1. Henry Miller, *On the Fringe: The Dispossessed in America*. (Lexington, Mass.: Lexington Books, 1991), 26. According to Gary Nash, *The Urban Crucible* (Cambridge: Harvard University Press, 1986), 115, the policy of “warning away” was used in the 1700s in Boston and other cities to prevent strangers from obtaining public assistance — a colonial version of modern-day “Greyhound therapy.”
2. Kim Hopper, “Deviance and Dwelling Space: Notes on the Resettlement of Homeless Persons with Drug and Alcohol Problems,” *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 391–414.
3. Miller, *On the Fringe*, 163, articulates this societal tendency as follows: “It was always more convenient to construe the problem (of homelessness) in terms of the deficiencies of human beings. These deficiencies were once attributed to moral flaws; today they are assigned to medical flaws. The common sense notion that homeless people are poor and that they need wages to purchase food and shelter have been ignored.”

Miller also notes the change in language associated with the homeless condition. "The 'drunk' or 'inebriate' has now become the 'alcoholic.' It is a significant change. Whereas the drunkard was a moral weakling, the alcoholic is a victim of forces outside his or her control . . . So, too, the 'vagrant' has become the 'homeless person.' Vagrancy is a crime; homelessness is a condition of being without shelter. *On the surface*, the new term appears to be more neutral, but, like the transition from 'drunkard' to 'alcoholic,' the shift from 'vagrant' to 'homeless' tends to mask the opprobrium concealed within the new language. Homeless people, today, are still thought to be a rather unsavory lot: witness the recent comment of former President Reagan, who claimed that, given the availability of public shelters, the homeless obviously choose their unhappy living state . . . In essence, the transformation of the root cause of a social problem from moral deficiency to illness changes the opprobrium attached to the problem only in form. To be a victim does not necessarily absolve the individual from the binder of stigma." Ibid., 161, 163.

4. Charles Hoch and Robert A. Slayton, *New Homeless and Old: Community and the Skid Row Hotel* (Philadelphia: Temple University Press, 1989), 3.
5. Ibid., 4.
6. Gerald R. Garrett, "Alcohol Problems and Homelessness: History and Research," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 301-32; Institute of Medicine, *Homelessness, Health, and Human Needs* (Washington, D.C.: National Academy Press, 1988); James D. Wright, *Address Unknown: The Homeless in America* (New York: Aldine de Gruyter, 1989).
7. Paul Koegel and M. Audrey Burnham, "Traditional and Nontraditional Homeless Alcoholics," *Alcohol and Health Research World* 2, no. 3 (Spring, 1987): 28-33; M. Robertson, "Homeless Veterans: An Emerging Problem?" in *The Homeless in Contemporary Society*, edited by R. Bingham, R. Green, and S. White (Beverly Hills: Sage Publications, 1987); M. J. Robertson, P. Koegel, and L. Ferguson, "Alcohol Use and Abuse Among Adolescents in Hollywood," *Contemporary Drug Problems* 16, no. 3 (Fall 1989): 415-52; Peter Rossi, *Down and Out in America* (Chicago: University of Chicago Press, 1989); Ellen L. Bassuk, Allison S. Lauriat, and Leonore Rubin, "Homeless Families," in *Homelessness: Critical Issues for Policy and Practice* (Boston: The Boston Foundation, 1987), 20-23.
8. James D. Wright and Eleanor Weber, *Homelessness and Health* (Washington, D.C.: McGraw-Hill, 1987), 77.
9. Wright, *Address Unknown*, 102.
10. Pam J. Fischer, *Alcohol, Drug Abuse, and Mental Health Problems Among Homeless Persons: A Review of the Literature 1980-1990. Executive Summary*. DHHS Pub. no. (ADM)91-1763(B), ADMHA (Washington, D.C.: U.S. Government Printing Office, 1991).
11. Wright, *Address Unknown*, 98.
12. Rossi, *Down and Out in America*, 40-43.
13. Hoch and Slayton, *New Homeless and Old*, 7-8. It is interesting to note that Hoch and Slayton did not include the policy of deinstitutionalization as a contributing factor to the growing numbers of homeless men and women. While deinstitutionalization has often been cited as a cause of the new homeless, several researchers have argued that the link between deinstitutionalization and the new homeless has been overstated. See W. R. Breakley, P. J. Fischer, A. J. Romanosk, and G. Nestadt, *Severe Mental Illness in the Homeless* (Boston: American Public Health Association 116th Annual Meeting, 1988); J. D. Wright, "The Mentally Ill Homeless: What Is Myth and What Is Fact?" *Social Problems* 35, no. 2: 182-91; D. A. Snow, S. G. Baker, L. Anderson, and M. Martin, "The Myth of Pervasive Mental Illness Among the Homeless," *Social Problems* 33: 407-23.
14. Nancy Kaufman, "Homelessness: A Comprehensive Policy Approach," *Journal of Urban and Social Change Review*, 17 (Winter 1984): 21-26.
15. Philip W. Johnston, Nancy K. Kaufman, and Amy A. Anthony, "The Massachusetts Approach to Homelessness," in *Homelessness: Critical Issues*, 53.

16. Counting the homeless is a difficult task, the value of which has been questioned. See Rossi, *Down and Out in America*, 45–81; Richard P. Applebaum, "Counting the Homeless," in *Homelessness in the United States — Data and Issues*, edited by Jamshid A. Momeni (New York: Praeger, 1990), 1–16. The size of a social problem often depends on where one stands. For example, the estimate of 350,000 homeless in the United States generated under the auspices of the U.S. Department of Housing and Urban Development in 1984 differed significantly from the 1.5 million suggested by homeless advocate Mitch Snyder. See *Report to the Secretary on the Homeless and Emergency Shelters* (Washington, D.C.: Office of Policy and Development, 1984), and Mary Ellen Hombs and Mitch Snyder, *Homelessness in America: A Forced March to Nowhere* (Washington, D.C.: Community on Creative Non-Violence, 1982).
17. See U.S. Conference of Mayors, *The Growth of Hunger and Homelessness and Poverty in American Cities* (Washington, D.C.: U.S. Conference of Mayors, 1986) and U.S. Conference of Mayors, *A Status Report on Homeless Families in American Cities* (Washington, D.C.: U.S. Conference of Mayors, 1987); U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1990: A 30 City Survey* (Washington, D.C.: U.S. Conference of Mayors, 1990).
18. Raymond L. Flynn, *Dignity and Respect: Making Room for Boston's Homeless*, (Boston: City of Boston, 1988), 11.
19. Nancy K. Kaufman, "Access to Housing for Homeless Substance Abusers," paper presented at Homelessness, Alcohol, and Other Drugs, a conference held in San Diego, California, February 2–4, 1989. See *Homelessness, Alcohol and Other Drugs*, (Washington, D.C.: DHHS Pat. No. [ADM] 89-1614, ADAMHA, 1989) for proceedings of the conference.
20. These data are derived from a listing of shelters, dated 4/12/91, provided by the Massachusetts Department of Public Welfare.
21. Raymond L. Flynn, *Commitment and Compassion: Boston's Comprehensive Policy for the Homeless Winter 1990–91* (Boston: City of Boston, 1991), 6.
22. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 54.
23. Hoch and Slayton, *New Homeless and Old*, 224.
24. *Ibid.*, 232.
25. *Ibid.*
26. Manifest functions are intended consequences of action and recognized by the participants as such. Latent functions are unintended and unrecognized consequences of action. See Robert K. Merton, *Social Theory and Social Structure*, (Glencoe, Ill.: Free Press, 1949), 49–61. Scrutiny needs to be given to policies that may operate to engender the reverse of what was intended. For example, priority access to benefits and housing is given to homeless people. This being so, some individuals may "become" homeless to gain an advantage on waiting lists for subsidized housing or to secure other benefits.
27. Flynn, *Commitment and Compassion*, 45.
28. For a description of the stabilization project, see Dennis McCarty, Milton Argeriou, Milly Krakow, and Kevin Mulvey, "Stabilization Services for Homeless Alcoholics and Drug Addicts," in *Treating Alcoholism and Drug Abuse Among Homeless Men and Women*, edited by Milton Argeriou and Dennis McCarty (New York: Haworth Press, 1990) 31–45. For an in-depth description of the shelter programming, see Milton Argeriou and Dennis McCarty, *Substance Abuse Programming in Shelter Settings* (Rockville, Md.: National Institute on Alcohol Abuse, forthcoming).
29. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 56.
30. Nancy K. Kaufman, *Massachusetts: A Comprehensive Policy Approach to Homelessness*, (Washington, D.C.: American Public Health Association Meeting, November 15, 1985), 8.
31. Johnston, *Homeless Individuals in Boston*, memo to Michael S. Dukakis, May 2, 1990, 3.

32. Kaufman, "Access to Housing for Homeless Substance Abusers," 12.
33. Ibid., 13.
34. U.S. Conference of Mayors, *Status Report — December 1990*, 51.
35. Ibid., 54, Appendix.
36. Ibid., Appendix question 12B.
37. Ibid., 50.
38. Fact Sheet — Massachusetts Coalition for the Homeless (Boston: Massachusetts Coalition for the Homeless, 1991).
39. *Streetlife: The Newsletter of the Massachusetts Coalition for the Homeless*, in press.
40. Ibid., April 1991, 4
41. Ibid., 2
42. Ibid.
43. Johnston, *Homeless Individuals in Boston*, 6.
44. Johnston, Kaufman, and Anthony, *The Massachusetts Approach to Homelessness*, 55.
45. Russell K. Schutt, "Shelters as Organizations: Full-fledged Programs or Just a Place to Sleep", in *Homelessness: Critical Issues for Policy and Practice*, 47.
46. The transformation of shelters from temporary emergency shelter facilities to permanent multiservice agencies is not achieved without difficulty. As Russell Schutt reports, based on his recent survey of workers at the Shattuck Shelter, "Shelters for homeless persons seek to respond both to their guests' emergency needs and to the fundamental problems of health and welfare that are often associated with homelessness. The need to provide both emergency and long-term services often strains shelter resources and at times creates conflicting demands on shelter staff." See Russell K. Schutt, Robert Burke, Marsha Hogan, Patricia Ingraham, Richard Lyons, Tatjana Merschede, Richard Ryan, Joan Sinkiewicz, Helen Stern, and Andrew Walker, "The Shattuck Shelter Staff: Work Experience, Orientations to Work and AIDS Awareness," unpublished report prepared for the Life Lines AIDS Awareness Prevention Project (Boston: Shattuck Shelter, 1991), 33.
47. Susan Sadd and Douglas W. Young, "Nonmedical Treatment of Indigent Alcoholics," *Alcohol Health and Research World* 2, no. 3 (Spring 1987): 48–49.
48. Madeline Stoner, "An Analysis of Public and Private Sector Provisions for Homeless People," *Urban and Social Change Review* 19 (1984) 3–8.
49. Johnston, *Homeless Individuals in Boston*, 3.
50. Soon to be published data deriving from the NIAAA-funded Community Demonstration Project in Minnesota, show intensive case management efforts with chronic homeless substance abusers to be generally unsuccessful in moving this subgroup out of their homeless/substance-abusing condition. Other data derived from the Health Care for the Homeless projects show short-term homelessness to be associated with gender, ethnicity, family ties, and the presence of dependent children. Women, nonwhites, high levels of family contact, and women with dependent children all show a tendency toward short-term rather than long-term homelessness. See James D. Wright and Eleanor Weber, *Homelessness and Health* (Washington, D.C.: McGraw-Hill, 1987), 55–56.
51. John P. Molloy, *Self-run, Self-supported Houses for More Effective Recovery from Alcohol and Drug Addiction: A Technical Assistance Manual* (Bethesda, Md.: DHHS Publication No. ADM [90-1678], 1990).

State Government's Response to Homelessness

The Massachusetts Experience, 1983–1990

Nancy K. Kaufman

When Governor Michael S. Dukakis reentered the State House in January 1983, he focused his inaugural address and priorities for his incoming administration on solving the problem of homelessness. This article describes the policy approach taken during his two successive terms as governor from 1983 to 1990, outlines the various steps taken to rally public and private support and resources on preventing the problem and on finding long-term, permanent solutions designed to solve it, and points to some of the lessons learned during these years of experimentation and innovation.

In January 1983, in Massachusetts and throughout the country, thousands of men, women, and children were wandering the streets with no place to go. At the time, as Massachusetts citizens were trying to develop a state program to address this problem, few models existed. In New York, the city had been sued by the National Coalition for the Homeless and was under a court order to provide shelter to all those in need. The court order led to the creation of hundreds of beds in large warehouse-type shelters throughout the city. Beyond that, New York City, like most major urban centers, had no organized response to the growing problem of homelessness. In the absence of any governmental action, religious organizations and grassroots groups were trying valiantly to provide a minimal "safety net," so that people would not freeze to death.

Returning to office in 1983 after a four-year forced leave of absence, Governor Michael Dukakis decided to make solving the problem of homelessness his top social welfare priority. Toward this end, he focused a major portion of his inaugural address on the homelessness issue.

There are some who would say that there is little we can do to help shape our children's future. There are others who would say that our immediate concerns are too pressing, and that we would do well simply to make government work more effectively and more honestly on the problems of our time.

Nancy K. Kaufman, former deputy director, Governor's Office of Human Resources, assistant secretary, Human Services, and deputy commissioner, Department of Public Welfare, is executive director, Jewish Community Relations Council of Greater Boston.

These are sensible warnings. And our present problems are indeed pressing . . . Thousands of homeless wander our streets without permanent shelter. And we must provide it. Too many of our people — black and white, men and women — in North Adams and Athol and Fall River and South Boston — are living at the margin without hope, without a future! And we must help them — not with handouts, but with jobs and good education and decent housing.¹

The governor assigned responsibility for coordination of this initiative to his newly created Office of Human Resources, under the direction of Philip W. Johnston, a former state representative from Marshfield with a reputation for progressive coalition building. I was hired as deputy director of the office and given primary responsibility for coordinating the governor's homeless initiative with all relevant departments of state government from secretariats as diverse as Elder Affairs, Communities and Development, Economic Affairs, and, of course, Human Services.

The Policy Development Process: Getting Started

The day after this address, the governor convened a meeting in his office of a broad cross section of the people who could work with his new administration to solve the problem of homelessness. To further demonstrate his personal commitment to the issue, he established the Governor's Advisory Committee on the Homeless and appointed his wife, Kitty Dukakis, cochair with a Catholic bishop from central Massachusetts. The governor invited eighty people, representing all sectors of the community, including clergy, advocates, service providers, foundations, businesses, and various professional groups, to serve on this committee. It divided into three working groups to develop policy and program recommendations regarding emergency services, social services, and permanent housing.

In addition to these three working groups, twenty-four local groups (nonprofit organizations and local governments) agreed to serve as "conveners." In that capacity, they brought together a variety of people to define the problem of homelessness at the local level. The governor, Mrs. Dukakis, and other state officials attended the first meetings of these groups. The information gathered through this process helped shape the overall development of policies and programs at the state level.

This broad array of groups and individuals produced a profile of the Massachusetts homeless population. The process demonstrated early on that the problem of homelessness is different in each area of the state. It also pointed to the importance of focusing not only on the emergency nature of the problem, but also on ways to both *prevent* homelessness and to find long-term permanent solutions.

The initial "Profile of the Homeless in Massachusetts"² emerged from the information gathered by the local conveners. This profile, published in June 1983, indicated that there were between 8,000 and 10,000 homeless people living either in shelters or on the streets. The survey also found that 30 to 40 percent had serious substance-abuse problems. At the time, only 25 percent of the total population consisted of families with children; by 1985, that percentage had grown to as high as 75 percent.³

The obvious questions that emerged from these alarming statistics were: What are the causes of homelessness? Can homelessness be prevented and/or solved? The causes are many and, in some cases, represent the failure of some of our major social welfare programs. The solutions are numerous, but they require money and

political leadership to be effective. This article analyzes the causes of homelessness and describes a framework for solving the problem that was developed and implemented in Massachusetts from 1983 through 1990. It also points to some of the lessons learned from the Massachusetts experience.

Diagnosing the Problem: The Causes of Homelessness

Deinstitutionalization

The deinstitutionalization of mentally ill individuals from state hospitals is often blamed for creating the homeless problem. While it is certainly one of the factors that contributed to homelessness, it is not the primary cause, even among mentally ill individuals. Deinstitutionalization is a social policy gone awry. The idea of emptying the back wards of overcrowded mental hospitals was not wrong, but its implementation was not accompanied by sufficient resources to provide the necessary community infrastructure of housing and case management services. Some model programs were developed, but in numbers insufficient to accommodate the thousands of individuals who returned to the community and the thousands more who were left in the community with no access to services because they had never been institutionalized.

Policymakers also erroneously assumed that mentally ill individuals could live independently in the community with the help of medication and without intermittent hospital care. While many people who were hospitalized can live productive lives in the community, many of them still need access to hospital care, and their families need ongoing support in their role as primary providers of health care.

The sheer number of people released into the community was more than the existing services system could manage. There were 24,000 individuals in Massachusetts state hospitals in the mid-1960s; twenty years later there were 2,400. Yet only 2,400 new community residential beds were made available for these individuals, many of whom were presenting themselves as homeless individuals to ill-equipped shelters. The fact that mentally ill individuals were sleeping in shelters and living on the streets should not have come as any great surprise to policymakers, yet, in 1983, many continued to resist acknowledging these facts. The approach of policymakers, as well as the attitudes of professionals, changed greatly in Massachusetts and throughout the country in the years that followed.

Alcoholism and Drug Abuse

A stereotypical image of a homeless person is the skid row alcoholic or "bag lady." While this group of people make up part of the homeless population, they are a minority of those who are in shelters. The problems of these people have grown more complex as they combined with drug abuse and mental illness. Whether alcoholism and drug abuse cause homelessness, or vice versa, the fact is that to be without a home and suffering from alcoholism or drug addiction creates additional stress for the individual and difficult challenges for the service provider. While this population group was more familiar to the large shelters, the use of alcohol and drugs, coupled with serious mental illness, presented new challenges and burdens to the existing shelter and outpatient systems. The simultaneous increase in drug-abusing homeless women with children further taxed an already overburdened care system.

Shortage of Housing

The shortage of affordable housing is probably the most critical cause of homelessness, particularly for families, but also for mentally ill and other disabled individuals. Over the past fifteen years, the federal government has reneged on its historical commitment "to provide a decent and stable environment for every citizen," as established in the National Housing Act of 1949. Under Presidents Gerald Ford and Jimmy Carter, the United States produced over 250,000 new units of low-income housing each year. Under the Reagan administration, that number declined to fewer than 25,000 units per year.

Not only were fewer units of affordable housing being built, but the units that already existed were disappearing. As William Apgar and James Brown pointed out in their 1988 housing study,

The supply of low-cost rental housing continues to shrink. Only one in four renter households with incomes at or below the poverty level lives in public or other subsidized housing. Some 5.4 million poverty-level renter households are left to compete for the dwindling supply of low-cost rental housing available in the private market. The result is further tightening at the low end of the rental housing market, and a growing rental payment burden for low- and moderate-income households.⁴

In addition to the problem of dwindling federal construction, the availability of low-income housing was further eroded by housing abandonments, condominium conversions, HUD property foreclosures, deteriorating public housing stock, gentrification, and rising costs of home ownership.

Lack of Income

Perhaps the most obvious cause of homelessness, as analyzed in 1983, was the lack of sufficient income to allow people to compete in the marketplace for housing, health care, and other basic needs. Thousands of individuals and their children are, and were in 1983, living below the poverty line as established by federal poverty standards. The amount of assistance provided for individuals, under the General Relief program, and for families, under the AFDC program, kept people in poverty. In response to this phenomenon, advocates for the poor in Massachusetts filed a lawsuit against the commonwealth, charging that the state was creating homelessness for families by failing to provide an adequate income for those in need. While acknowledging the "poverty gap," the state responded by investing significant dollars in assisting individuals to "find a route out of poverty," rather than to keep them poor and dependent.

This investment was a substantial one in the years 1983–1990 and took the form of a variety of investments in infrastructure and direct subsidies in the areas of housing, employment, and day care. To this end, over 80,000 women on AFDC left the welfare roles for decent paying jobs, and over 15,000 families were placed in permanent housing.

Other Factors

Domestic violence, family turmoil, and lack of child support are other causes of homelessness, particularly for women and children. These may combine with some or all of the causes already mentioned to create a crisis in one's life resulting in the loss of a place to call home. A woman who is faced with such a crisis and lacks the education and/or skills to become self-sufficient may find herself dependent on government assistance, which may be insufficient to meet her basic needs.

Toward a Solution: A Framework for Action

In Massachusetts, after a thorough analysis of the causes of homelessness and its manifestation at the local level, a bold four-pronged strategy was created for solving the problem. It included prevention, emergency services, supportive services, and permanent housing (see Figure 1).

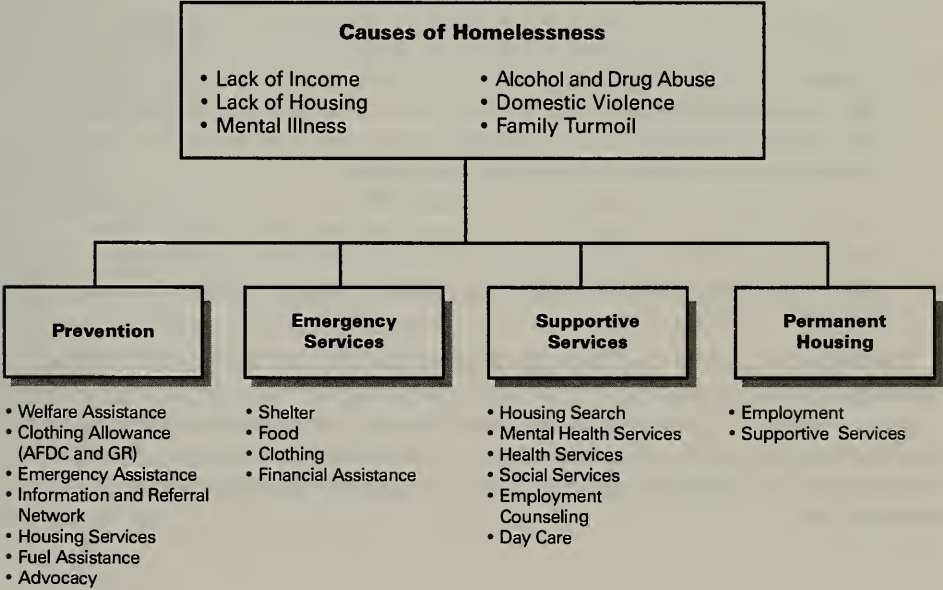
Prevention

The model assumes that, to the extent possible, productive fiscal and human investments to prevent homelessness should occur first and foremost. One of the first steps Massachusetts took toward this goal was the passage of An Act to Prevent Destitution and Homelessness, which became a model piece of legislation for the nation. Known as Chapter 450 of the Acts of 1983, the legislation amended the statutes of various state agencies involved with services to homeless. The agencies affected included Executive Office of Communities and Development (EOCD), Executive Office of Human Services, Department of Social Services (DSS), Department of Mental Health (DMH), and Department of Public Welfare (DPW). Because of the crisis proportions of the problem, the governor included an emergency letter that made the act official the day it was signed, October 27, 1983.

A number of the sections of the act applied to the Emergency Assistance Program at the Department of Public Welfare. The act specified regulatory changes to expand the program's preventive elements, all of which are 50 percent reimbursable by the federal government. Another feature of the bill removed the permanent address restriction from the state-funded General Relief program, thus enabling homeless individuals to receive assistance.

Figure 1

Homelessness: A Continuum of Services



Other innovative prevention programs included:

- The Family Reunification Program, which allowed AFDC single parents to continue to receive full benefits even if a child was removed from home as long as the family reunited within nine months
- The Housing Services Program, which provided funds to nonprofit agencies to work with landlords and tenants through mediation, counseling, and negotiation in order to prevent unnecessary evictions
- The Housing Abandonment Program, which provided funds to bring multi-family properties threatened with abandonment back to stable ownership and tenancy
- The Condominium Conversion Act, which protected low- and moderate-income households from being displaced due to condominium conversion
- The Homeless Family Prevention Program, which was designed to help stabilize families in existing housing so they did not become part of the shelter system.

A major initiative to prevent families from becoming homeless was included in the governor's fiscal 1988 budget submission. While only partially adopted by the legislature, the initiative sought a major overhaul of the system of incentives, disincentives, and services for women and children at risk of homelessness. The initiative proposed the reallocation of existing funds along with new funds targeted to preventing women with children from ever having to enter the cycle of homelessness.

A major feature of the new program was incentives designed to keep families in existing housing or, if necessary, to assist families in finding affordable housing without first having to become homeless. As described in the budget narrative,

By redirecting existing services and programs to families at risk of becoming homeless, we will be identifying problems before they become critical and helping families remain in their communities, generally at substantially lower rents than those that would be charged in a new home. Furthermore, by helping families remain in their existing housing, we will be avoiding other related costs, such as educational and health costs for homeless children . . .

The homeless prevention program recognizes that in addition to the economic causes of homelessness, there are other factors that may cause a family to lose their housing. It offers a comprehensive approach to identifying families who may be at risk and providing them with appropriate services and support to stabilize their situation.⁵

The Department of Social Services was given an expanded role in determining whether or not the children in a given family were at risk as a result of the family's housing situation. Coupled with an assessment by the Department of Social Services, a special voucher program focused on giving housing subsidies to these at-risk families without first forcing them to enter a shelter and the vicious cycle of homelessness.

Massachusetts combined these programs with other existing prevention programs to decrease the need for emergency services. Only after all possible prevention efforts were applied did emergency services become necessary.

Emergency Services

In 1983, Massachusetts supported only two shelters for homeless people. By 1990, over 100 shelters existed, of which 70 were for families with children. Except for a few large (200–300 bed) shelters for individuals, the shelters that were created were small, community-based projects with 20 to 40 beds, run by nonprofit agencies under contract with the state. Each received 75 percent of its operating funds from the Department of Public Welfare and provided a stable bed and meals, as well as social and housing search services. The remaining 25 percent came from private and in-kind contributions.

To help the nonprofit sponsors raise the capital funds required to purchase sites and complete necessary renovations quickly, Kitty Dukakis personally intervened and asked the philanthropic and business communities to join her in creating a Fund for the Homeless. The fund was housed and given initial start-up funds by the Boston Foundation and raised over \$1 million from corporate and individual donors to fund start-up activities and respond to the emergency capital needs of the shelters.

In addition to the shelters, the state also used a limited number of hotels and motels for homeless families when space in shelters was unavailable or inaccessible. The average length of stay in a hotel was ninety days, while in a shelter it was sixty days. Shelters were clearly preferable to hotels because they could provide services, but neither solution was ever considered adequate as a replacement for permanent housing. In fact, most shelter providers looked forward to the day when they could go out of business or convert their structures to affordable housing. Shelters must serve as a temporary emergency response that will be phased out as permanent housing is available. Hotels and motels served as a last-resort measure, preferable to the streets, but inadequate for long-term sheltering. After a sharp increase in the number of families being housed in hotels and motels, in 1989 the state focused considerable attention on bringing down the number sheltered from a high of over seven hundred in November 1988 to a low of under one hundred by the end of 1990.

In addition to emergency shelters, the state funded special shelter programs for substance abusers, battered women, adolescents, parenting teens, and mentally ill individuals. For some of these groups, additional supportive services are necessary to bridge the gap between emergency shelters and permanent housing.

Supportive Services

The third aspect of the Massachusetts model involved supportive services. This strategy was based on the assumption that in order to move from homelessness to permanent housing, individuals need certain supportive services. These include everything from basic information and referral services to child care, employment and training assistance, housing search, and transitional living programs.

In this area, particular attention was given to the needs of mentally ill individuals. In 1985, Governor Dukakis submitted to the Massachusetts legislature a \$170 million Comprehensive Plan for Services to the Chronically Mentally Ill. The plan

called for improved case management, inpatient services, and housing services for homeless and seriously mentally ill individuals. In 1987, the legislature approved the plan, having increased the funding to over \$300 million. The plan included 3,500 units of housing and a vastly improved hospital inpatient and outpatient care system, which relied on a combination of public and private facilities. Public (Department of Capital Planning and Operations, DMH, EOCD) and private, nonprofit agencies were to develop housing programs for the mentally ill, with inpatient services provided by accredited, rebuilt state hospitals.

Other critical supportive services included health services, day programs, employment and training programs, veterans services, and transitional living programs. The latter were to be developed through a unique partnership between human services agencies and housing authorities that pairs housing subsidies attached to units with operating dollars attached to services for particular residents.

Permanent Housing

Early in the policy development process, it was decided that unless priority was given to permanent housing, the strategy would ultimately fail. Toward this end, Governor Dukakis signed into law three comprehensive housing acts, accompanied by over \$1 billion in bond authorizations, for the development of low- and moderate-income housing. These funds supported a variety of housing for families, special needs individuals, and the elderly; housing innovations; renovation and modernization; abandonment prevention; and state housing assistance for rental production. Over 5,400 new units of housing were put into the development pipeline during these years.

In addition to the above programs, the state's Chapter 707 program (the state equivalent of the federal Section 8 program) has generated thousands of new units of subsidized housing. More recently, the state's Home Ownership Opportunity Program is helping to make homeownership a reality for first-time buyers, thus freeing up units in the rental market.

In the summer of 1990, the Department of Public Welfare took advantage of a discretionary request for proposals from HHS and HUD and submitted an application for a model program to use emergency assistance funds as a financing stream for developing permanent housing for homeless families. Massachusetts was one of three states to receive significant funding (approximately \$6 million) over a three-year period.

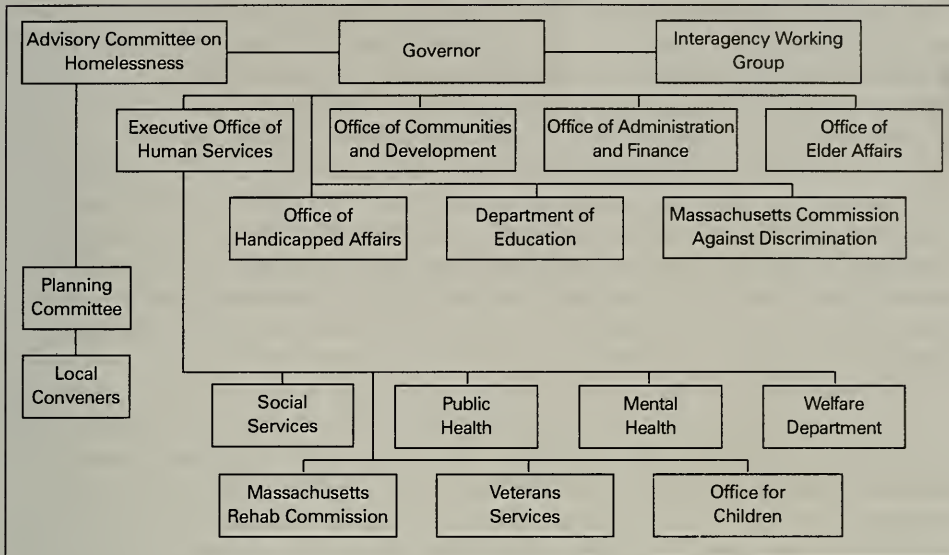
A Working Solution: Implementing the Massachusetts Model

The success of Massachusetts's approach to alleviating homelessness depended on the state's ability to form partnerships with local governments, the private and nonprofit sectors, and the religious community. The approach also required a full assessment of state policies and programs and the extent to which they contributed to the homelessness problem. The model was based on the assumption that homelessness was not a new social problem, but represented the failure of many different social policies and programs.

Rather than create a new bureaucracy to deal with homelessness, Governor Dukakis pushed the existing government bureaucracy to develop and implement creative interagency solutions. The initiative was originally coordinated through the

Figure 2

Homelessness Policy Coordinating Structure



Governor's Office of Human Resources. Beginning in July 1984, the Executive Office of Human Services became the lead agency. Throughout the entire period under discussion, many different state agencies were involved in planning and implementation. To ensure maximum coordination, the deputy director of Human Resources, and later the assistant secretary of Human Services, was responsible for chairing the interagency coordinating committee (see Figure 2).

The Governor's Advisory Committee on the Homeless provided an overall mechanism for involving care providers, advocates, and state officials in the policymaking process. A planning committee, which met monthly, was also chaired by the assistant secretary of Human Services. It ensured regional input and an opportunity for more intensive review of proposed policy changes. Conveners from throughout the state were represented on the committee to ensure that information flowed as smoothly as possible. Ad hoc task forces were created as needed to deal with specific policy issues. Examples of these included a DPH/DSS/DPW working group, which developed a special set of programs targeted for homeless women, with children, who had substance-abuse problems, and a DPW/DSS/EOCD working group, which designed the homeless family prevention program described earlier. Other groups focused on winter planning, veterans services, and other special projects such as the innovative emergency assistance project funded by HHS.

Special training programs were developed as policies and programs evolved. Welfare case managers, for example, were trained to include housing as one of the areas they explored with clients at intake and redeterminations for eligibility. If and when someone appeared to be homeless, or at risk of becoming homeless, the person would be referred immediately to housing search workers for assistance in finding housing. If a family was in a shelter, housing search was one of the services reimbursed by the Department of Public Welfare so that lengths of stay in the shelter

could be minimized. Similarly, if a family was in need of supportive services, referrals were made to the Department of Social Services or whatever state or nonprofit agency might be most appropriate to assist the individual or family.

Throughout the implementation of this model, the guiding principle was to assist clients in finding routes out of poverty. For clients of the Welfare Department, this involved focusing on those areas which could combine to accomplish this goal: child support, housing, health care, and employment. Considerable attention and resources were directed to these areas in order to help each client become self-sufficient.

For clients of the Department of Social Services, the strategies involved family life education, day care, and counseling to help resolve the crisis and move toward family reunification and self-sufficiency. For mentally ill individuals, the strategy was to provide the necessary medical treatment along with appropriate housing and day services. Finally, the strategy for substance-abusing individuals was to assist them in gaining access to appropriate treatment services with plans for aftercare, including housing and supportive services.

The fragmentation of the human services delivery system did not always lend itself to interdisciplinary models. However, whenever and wherever possible, attempts were made to bring agencies together to develop solutions to the homelessness problems of multiple population groups. With the kind of top-down leadership provided by the governor, secretariats, and commissioners, the bureaucracy received a clear message that working together to solve the problem of homelessness in Massachusetts was the single most important social welfare priority. Budget decisions that reinforced this message were often made, even in times of scarce resources. And during his presidential campaign, the governor continued to focus on this issue both locally and nationally.

Lessons Learned from the Massachusetts Experience

Many lessons can be learned from the Massachusetts experience from 1983–1990. First, prevention of homelessness must be a key ingredient in any successful strategy. Simultaneously, there must be a focus on long-term solutions, including employment and permanent housing. Massachusetts developed an approach which began to demonstrate that the problem *can be* solved. More than 15,000 families were placed in permanent housing. During the winter months, no family or individual was forced to be on the streets. A combination of aggressive case management, housing services, and income supports helped thousands avoid homelessness. The Massachusetts policy also recognized and focused on the special needs of the mentally ill. This in no way implies that the entire problem of homelessness was solved, but an infrastructure was created that went a long way toward laying the foundation for long-term solutions.

The challenge for government at all levels is to target limited resources where they can have the greatest impact. Choices inevitably have to be made, but if the right people participate in making those choices, success is much more likely. In the final years of this initiative, Massachusetts reached the limits of its own resources available for solving the problem. The budget for homeless programs increased from \$10 million in fiscal year 1983 to over \$200 million in fiscal year 1989, not to mention the large increases in related program budgets. Unfortunately, more homeless people continue to enter the system. Although the state helped thousands of people

find permanent housing, thousands more remain at risk of becoming homeless. As more and more of the safety net programs are dismantled and the prevention initiatives are removed, the danger exists that the number of people entering the system will increase, resulting in far greater fiscal costs for the commonwealth of Massachusetts, not to mention the human costs.

Policymakers still disagree about the causes of homelessness. Some argue that the system itself discourages people from staying in their own homes. Others claim that some people simply "like" sleeping on the streets. Still others claim that we have merely scratched the surface of the more basic problems of lack of income, lack of jobs, and lack of affordable housing.

Whatever the causes of homelessness, the fact is that thousands of people become homeless each year in Massachusetts and throughout the country. In Massachusetts, a working model for solving the problem was created, but basic questions remain: Do we, as a commonwealth, want to solve the problem, and at what cost? Has too much been devoted to emergency responses and not enough to prevention? Can we build permanent housing fast enough and affordable enough for the poorest citizens to benefit? Are we willing to guarantee a job to anyone who wants one despite age, ethnicity, or disabilities? and, What role does government have in finding solutions to the problem?

These are the questions with which we as a commonwealth now struggle. The answers are not simple. One thing is certain: the problem of homelessness is expensive to solve, particularly if one considers the thousands of men, women, and children affected each year. The loss of future productivity of the injured children alone should be sufficient to cause us to invest early in preventing the problem. Millions, if not billions of dollars have already been spent on responding to the emergency by funding ever increasing numbers of shelter beds. While Massachusetts can be proud of its high-quality shelter delivery system, it should not be satisfied with it as a response to the problem.

For years, the bureaucratic funding maze of federal and state funds made solving the problem a planner's nightmare, as articulated by Newman and Schnare in their insightful article on the subject.

In reality, then, there are two streams of government financing of low-income housing — a housing stream and a welfare stream. Government involvement is shared by two federal agencies, HUD and HHS, and a multiplicity of state and local jurisdictions.

But their approaches are uncoordinated and potentially overlapping. Furthermore, there are stark disparities in the amount of shelter assistance that the systems provide: similar people are not treated similarly. This two-pronged approach to shelter assistance, through a mix of income maintenance and housing programs, raises serious questions regarding the efficiency, equity and overall effectiveness of the existing system.⁶

Most states' policies mirror the uncoordinated efforts of the federal government to date. In Massachusetts, we have tried to take a more comprehensive policy approach to the problem. The discretionary funds received from the HHS/HUD initiative was a hopeful sign that the problem has been recognized and some efforts are under way to change the approach to solving it toward a more integrated model. The passage last year of the Comprehensive Housing Act of 1990 is another recognition of the need for a national solution.

Less encouraging, however, is the public's increasing acceptance of soup kitchens,

shelters, and street people. In 1983, the harsh realities of homelessness were carried on the evening news and the front pages of all our newspapers as horrors for our country in this postindustrialized "affluent" period in our history. This well-publicized compassionate portrayal of the problem motivated thousands of people to volunteer time and money and lend political support to finding viable solutions. Unfortunately, the public's attention span is short, and we have grown to accept the problem as a reality of everyday life in America.

While Boston, for many years, could proudly compare itself with New York, Los Angeles, and Washington, D.C., as responding more effectively and more compassionately, I fear that those comparisons may quickly disappear. The cutbacks in public assistance, social services, housing, and mental health do not bode well for the future. It would be tragic if the infrastructure built over eight years of careful planning and program development was torn apart in an effort to balance the state budget. The short-term fiscal gains may look significant, but the long-term costs would be very serious. In the final analysis, if we, as the richest nation in the world, cannot guarantee a decent home for every citizen, who will? ■

Notes

1. Governor Michael S. Dukakis, "Inaugural Address," January 1983.
2. Governor's Office of Human Resources, "Profile of the Homeless in Massachusetts," June 1983.
3. Carol Johnson, "Study of Homelessness," Executive Office of Human Services, Commonwealth of Massachusetts, December 1984.
4. William Apgar, Jr., and H. James Brown, *The State of the Nation's Housing, 1988* (Cambridge: Joint Center for Housing Studies, Harvard University, 1988).
5. House 1 Budget Narrative, fiscal year 1988, submitted by Michael S. Dukakis.
6. Sandra Newman and Ann Schnare, "Integrating Housing and Welfare Assistance," M.I.T. Working Paper no. 12, 1988.

Policy Shifts in the Massachusetts Response to Family Homelessness

Margaret A. Leonard, L.S.A., L.I.C.S.W.
Stacy Randell

Massachusetts's response to the tragedy of family homelessness during a period of economic prosperity (1983–1987) is contrasted to a period of economic decline (1988–1992). The article describes the movement toward a structural response in the boom years and its dismantling with the emergence of a “blame the victim” response in the decline years. The roles of state government, advocacy groups, human service providers, private funding sources, academic institutions, and the media, as they influence these responses, are outlined. Interviews with key actors in these groups, group interviews with formerly homeless women, a review of the literature, and the authors' direct experience in the field provide concrete evidence from which conclusions are drawn.

Competing Causes of Family Homelessness

Family homelessness has increased dramatically in the past ten years within the commonwealth of Massachusetts and nationwide. There has been considerable discussion about the causes of its rapid growth. Perception of cause is critical to the choice of strategies employed to respond to it.

In a comparative federal study, “Homeless Families with Children: Programmatic Responses of Five Communities,” cause is described as political, economic, social, or individual, with an array of detrimental consequences.¹ Structural causes are the root of family homelessness, while individual or family pathology is a major precipitating cause. These two sets of causes are frequently set in opposition to one another, as they can support opposing ideologies. This is best illustrated by the conceptualization of William Ryan in *Blaming the Victim*, in which he describes the “exceptionalist” versus the “universalist” ideology.² Ryan's interpretation applies to the general conditions of poverty, but it can equally be applied to the specific issue of homelessness.

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Proponents of the exceptionalist position see the cause of family homelessness as pathology/deficits within its victims as primary and social, economic, and political causes as secondary. Supporters of this position define homeless families as a distinct subcategory that needs specialized human services. It supports the growth of a human service system that addresses pathology in a specific category of individuals and families — in this instance, homeless families. John McKnight calls such a system a “comprehensive, multi-disciplinary, coordinated, interagency service system. It is the equivalent of institutionalization without walls or the design of an environment to create a totally dependent service system consumer.”³ The exceptionalist position legitimates the status quo and calls for only incremental changes in public policy.

This position has its roots in history when the English poor laws became the foundation for evolution of public policy based on the distinction between the deserving and undeserving poor. It gives rise to the “blame the victim policy,” an American ideology that all too frequently resulted in misaligned public policy that hurts poor people.

In contrast, proponents of the universalist position see social, economic, and political causes that sustain endemic poverty and marginalization as primary. Family problems are often exacerbated through a struggle to survive in a basically unjust system. Supporters of this view argue against categorizing homeless families as a distinct and separate entity. Inadequate income and out-of-control housing costs are the factors that cause homelessness to increase today. They advocate public policy changes designed to give poor families equity in access to resources and call for a comprehensive analysis of the systemic causes of poverty that exacerbate homelessness and the need for radical social change.

Our Perception

We, as human service providers committed to the universalist position, advocate a structural response to family homelessness. We propose that the causes of homelessness be perceived from the perspective of its victims and that homeless persons be organized and involved as advocates in the process of social change. A view of family homelessness from the State House, the hallways of academia, clinical professional perspective, or the kitchen table of a family shelter reveals different perceptions of cause. A view from the experience of the victims identifies lack of affordable housing, inadequate income, unequal access to resources like child care, skills training, and education as key factors.

Homeless families are just like other poor families. What differentiates them is that they have been burned out, evicted, or have exhausted the good will and resources of family, friends, and acquaintances in doubled-up accommodations and sometimes threatening environments. Many of them have extraordinary survival skills. They have the same desires and aspirations to be good parents, to be responsible and independent adults, and to make the American dream come true for themselves and their children. They are ashamed that the dream turned to nightmare and that they are in cars, on the street, in doubled-up situations, or in hotels, motels, and shelters.

We regard the exceptionalist response to family homelessness as misdirected. The building of an alternative human service system for a separate population of home-

less families is costly and ineffective. Poor families fall out of housing because of inadequate income and the profit structure of housing. They should be placed in permanent housing. Public policy should then be focused on the creation of supportive, neighborhood-based services that all poor families need for their growth and development. These include day care, recreational facilities, human development and educational programs, support groups, substance-abuse programs, and community-based organizations and associations. In the past several years we have seen the erosion of such a communal infrastructure in many poor neighborhoods.

What accompanies the exceptionalist position is blaming the victim, an ideology that is embedded in the culture of the United States. Even when it has receded into the background for a time, it can all too easily rear its ugly head. Perhaps its most devastating effect is what it does to its victims, giving them this message: you are inadequate, deficient, ill, something is wrong with you. The tragedy is that the message becomes interiorized and the target group accepts the verdict. This can result in the depletion of self-esteem, which generates dependency and creates conditions in which personal and family pathology thrive.

Our second core belief is that real change comes from the bottom up. Homeless families themselves must be engaged as active participants in the change process. Acting as their own advocates, in collaboration with others, is empowering, heals blame, and keeps the advocates and human service providers focused. We need to make organizational links between homeless families, AFDC (Aid to Families with Dependent Children) families, and low-income families, who are equally at risk of becoming homeless. Group power and action inclusive of the organization and presence of homeless families is the basic vehicle for social and institutional change.

We argue that during the economic boom years, 1983–1987, there was a movement in the commonwealth of Massachusetts to provide greater access to shelter, housing resources, and other financial benefits for homeless families and families at risk of being homeless. However, we also argue that when resources dried up and the problem continued to escalate in the years of economic decline, 1988–1992, the institutional gains of the boom years were gradually stripped away. The blame-the-victim ideology was often employed as the rationale for these changes.

The Economic Boom Years: 1983–1987

Homelessness in Massachusetts grew rapidly in the 1980s, particularly among its most vulnerable victims, economically disenfranchised women and children. These were the years of the “Massachusetts Miracle” for some, but for others they were the years of the trickle-down illusion. “The economic recovery of the 1980s bypassed many American families with children. Far from becoming prosperous, millions of families now find themselves without enough income to ensure a decent standard of living — including stable housing — for their children. Family incomes were hurt by a number of factors, including changes in the job market and falling wages, a ‘safety net’ so weak it pulls few families out of poverty, and a growing number of one-parent families.”⁴

Young families headed by persons younger than thirty years of age “saw their median income fall by 13 percent between 1973 and 1987; the incomes of young families with children fell by 24%, of black families by 33%, of Latino families by 19%, and of female-headed families by 22%.”⁵

In the early years in Massachusetts, over 90 percent of homeless families were recipients of AFDC. AFDC grants had not been adjusted to inflation for several years. Between 1960 and 1980, AFDC grants decreased by 56 percent. This left AFDC families extremely vulnerable to an escalating real estate market.

The average monthly AFDC grant for a family of three in 1986 was \$426, while the fair market value for a rental apartment well exceeded the allotment. Less than a third of AFDC families were in subsidized housing. One advocate we interviewed commented that "in 1980, poor people could still bounce from apartment to apartment because housing costs weren't so exorbitant. The situation was much worse by 1983, since families on AFDC received no grant increases for several years, and the market boom and gentrification had taken effect."

Insufficient income, unaffordable housing, and a dearth of subsidies resulted in the escalation of family homelessness. In 1983, homeless families were relegated to cars, the streets, or moving from place to place in doubled-up conditions to whoever would take them, overcrowded and unwanted. Such scenes shocked the moral conscience of the citizens of Massachusetts. There was a sense of moral outrage that cried out for something to be done. These conditions shaped the state's agenda in the early years: access to emergency shelter and to resources for subsidized housing.

In the fall of 1982, William Hogan, secretary of the Executive Office of Human Services (EOHS) in the outgoing Edward King administration, gave the green light to the Department of Public Welfare to craft an initial response. Elyse Jacob, a former human service advocate commissioned to conduct this research on behalf of state government, immediately engaged the advocacy and human provider community in the process. This initial work took on a life of its own when Governor Michael Dukakis, during his January 1983 inaugural address, declared that combating homelessness would be a number one priority of human service in his administration. The leadership of state government had declared its commitment to eradicate homelessness, and this had a decisive influence on Massachusetts's movement to a more systemic response to family homelessness in the early years.

Structural Response to Family Homelessness

The movement to a systemic response consisted of two basic developments. The first was the passage of Chapter 450, which provided an emergency service program for homeless and at risk of being homeless families. The second was the procuring of greater access to subsidized housing certificates for homeless families.

Chapter 450: Emergency Assistance

In the fall of 1983, Chapter 450 of the Massachusetts General Laws was enacted by the legislature. It mandated the commonwealth to provide a program of emergency assistance (EA) to needy families. EA addressed homelessness in two ways: (1) It prevented homelessness by providing rent, mortgage, and utility arrearage for low-income families who were at risk of being homeless. The commitment to this program, which began in 1983 with \$2 million, expanded to \$8.3 million in 1987. (2) It also provided payment for shelter and hotel/motel costs for homeless families, as well as cost of furniture storage and first month's rent, security deposit, and moving expenses when families moved from shelter into permanent housing.

Families were living on the streets, a situation that needed an emergency response. Affordable housing, a long-term solution, was not immediately available, so shelters were considered the best answer. Massachusetts availed itself of the experience of advocates. It did not create barrack-type dwellings for families as was done in New York State. A unique and replicable model was created. Family shelters were designed as small dwellings in residential neighborhoods with supportive financial and political roots in local communities. Besides food and shelter and a place to feel safe and secure, these programs provided housing search, family life education, information and referral, case management, transportation reimbursement, advocacy, access to health and educational services, and follow-up services. This family shelter model was unique in the nation. As stated in a comparative federal study, "Shelters in Massachusetts resembled Transitional Programs in many other cities especially if the shelter has undertaken to develop social service linkages beyond those reimbursed by DPW."⁶

The state commitment to this response is documented by its growth. In 1983 there were three family shelters, while in late 1987 fifty-eight were geographically distributed throughout the state.

In "A Service Model for Homeless Families," the Massachusetts Shelter Providers Organization in 1986 identified its support for an economic response to family homelessness. "Homelessness is a situation, not a population. Homeless families are a diverse group and represent many segments of our society. In working with families in a variety of shelters as well as hotels/motels, it has become clear that the needs of homeless families are similar to the needs of all other families. The main difference for these families is that they are in crisis due to the lack of permanent housing and receptive support systems."⁷

In addition to family shelters, which had a bed capacity of slightly over 500 beds in late 1986, the state used hotels and motels to house homeless families. The choice of hotels/motels to handle the increasing number of homeless families was riddled with problems. Costs were exorbitant and greatly exceeded shelter costs. Conditions were inadequate, unsanitary, unsafe, and inappropriate for families with young children. By mid-1987, 684 families were housed in hotels and motels by the state. The media and advocate community dramatized the suffering of these families and the exorbitant expenditures entailed. They challenged the state to redirect these moneys to provide permanent housing for homeless families. This pressure played a positive role in highlighting the need for greater access to subsidies and set the stage for a major focus on access to subsidized housing. As one of our interviewees put it, "The legislature's commitment to reduce the hotel/motel count opened the door for greater access to 707's [the state subsidized housing program]."

Access to Subsidized Housing

Each year, thousands of subsidized housing resources, funded by the federal government, and with already appropriated state funds, turn over and are made available for new applicants. Only a small proportion of these resources has gone to homeless and/or AFDC families. The primary reasons for the substantial failure to deliver existing resources to homeless families are failure of housing authorities to give priority to homeless, procedural and administrative barriers, and discrimination.⁸ Advocates believed that homeless and AFDC families were too frequently left out

of EOCD, the state's housing agency system. Advocates joined with state government employees to gain greater access to both the state and federal government's housing resources.

In fiscal year 1986, the Department of Public Welfare and the Economic Office of Community Development (EOCD) established a special pilot program to provide state-funded Chapter 707 rent subsidies to homeless families, called set-asides. In fiscal year 1987, the legislature expanded funding for the program and more than 900 homeless families found housing with Chapter 707 certificates. Gains were also made in access to Section 8 vouchers and certificates (subsidized by the federal government), as well as to other subsidized units in the state.

In assessing the effectiveness of this response, these figures speak for themselves. In 1983 less than one third of the AFDC caseload had subsidized housing, but by 1992, 44 percent of an increased AFDC caseload have subsidized housing. Since 1983, 12,000 formerly homeless families have been placed into permanent housing with subsidies.

Homelessness Prevention Initiative

In late 1987, Governor Dukakis proposed an initiative aimed at stopping homelessness before it started. In his fiscal 1989 House 1 budget he requested an additional \$21.8 million to fund this prevention effort. This initiative mandated all appropriate state agencies to collaborate to implement a response, including the Executive Office of Human Services, the Executive Office of Community Development, the Department of Public Welfare, the Department of Social Services, the Department of Mental Health, and the Department of Public Health. Extended to include advocates and human service providers throughout the state, the collaboration provided an interdepartmental forum in which the key elements to prevent homelessness could be discussed: rent subsidies, child care, housing search, education, health care, case management. The initiative did not make it through the legislature, and these efforts fizzled.

Influential Factors in Massachusetts's Boom Year Response

Several factors helped shape a structured response to family homelessness in the boom years, one of the most important of which was the leadership of the Dukakis administration. "Homelessness was the governor's number one priority. It therefore gained budget, policy, and media attention," says one former public servant. A statewide Commission on Homelessness, chaired by Kitty Dukakis, was formed to oversee the implementation of this priority.

Advocacy Groups

Advocacy groups were ready to move on the issue in 1983. The Massachusetts Coalition for the Homeless was formed in the early eighties to advocate for the homeless. It had forged bonds with the Coalition for Basic Human Needs, Greater Boston Legal Services, and Massachusetts Law Reform. They had collaborated on the Up to Poverty campaign, which sought to upgrade AFDC grants for families. These groups were extremely instrumental when they focused their combined attention on the homeless.

In 1985 an organization of human service providers, later the Massachusetts Shelter Providers Association, was in its early stages of formation. Members of this association came from the nonprofit world, churches, community-based agencies, and neighborhood associations. Providers of service to the homeless first on a voluntary basis, they later became Department of Public Welfare-funded shelters in a contractual arrangement with the state. These groups were close to the real needs of homeless families. Their roots were not in traditional human service systems, so they brought a freshness to the issue that led to quick identification of economic, political, and social causes.

Collaborative Links among Key Actors

An atypical synergy existed among strange bedfellows in the early years. Human service providers, advocates, public servants, private funding sources, media, and to a lesser extent the academic community agreed in naming declining income and high housing costs as the causes of family homelessness. Together they tried to shape public consciousness and marshal public and private resources to respond to the need for emergency shelter and permanent housing. Former advocates active in the King administration were later hired by the Dukakis administration and appointed to key state positions. These newly appointed public servants valued the grassroots community experience and created channels for these voices to be heard within state government.

Private foundations were also part of the collaborative. The Fund for the Homeless played a uniquely supportive role in the early years. It complemented state funding through the provision of capital grants to new shelter programs. This was followed by STAP, Shelter Technical Assistance Project, which advised shelters in critical administrative and program development areas. The third phase of the fund's response is Beyond Shelter. "Its purpose was to provide resources for public education, constituency development and coalition building among the direct service, development and advocacy organizations at work in Massachusetts. Its overarching purpose is to promote broad based citizen action to end homelessness."⁹

Strong links with the media were forged. Efforts to work with the media were proactive and coordinated through the collaborative. While the media dramatized the human tragedy of homelessness especially during the holidays, they were quite sensitive in identifying the systemic causes. They focused on the issues and continued a dialogue with the advocacy community. Bashing the victims or state government was much less apparent.

In the economic boom years, Massachusetts made a serious commitment to respond to family homelessness. The Department of Public Welfare played a major role in this effort. The state's commitment was hampered in these years of the Reagan era, with its substantive federal cuts in human services and its major retreat in the area of low-income housing development. The gains, however, were significant for thousands of homeless and at risk of becoming homeless families in Massachusetts.

They included:

- Growth of a humane model of family shelter geographically distributed throughout the state

- EA arrearage payments (back payments for rent, mortgage, or utilities), which prevented many families from joining the ranks of the homeless, and financial supports to assist homeless families in the move to obtain and maintain permanent housing
- Improved access to Section 8 (federal) and 707 (state) subsidies, as well as other subsidized units
- Creation of a forum in which key actors in state government, advocates, human service providers, homeless persons, and private funders could communicate and plan strategies to respond to family homelessness

Testimony from the victims of homelessness speaks to some of the gains of the Massachusetts response in these years. Wellspring, a family shelter in Gloucester, Massachusetts, recently completed a research study based on a survey of seventy-nine formerly homeless women who were residents of the shelter during the 1980s, "We Are Like You." It reveals that 94 percent of the women have survived homelessness and are still in permanent housing. All but two of the respondents indicated that their lives were dramatically better than when they were at Wellspring."¹⁰

Two formerly homeless women were among our interviewees. One, who is employed full time, says, "I met people who believed in me and helped me to believe in myself." The second, who just completed four years of college and is in her first year of teaching in the Boston school system, reports, "The doors were open to me through the shelter. I got health care for my failure-to-thrive daughter, an apartment, child care, education, and friendship that supported me all along the way." Both women are members of the board of directors at Project Hope.

The movement toward an increasingly systemic approach was expressed in a recent federal study.

To a greater extent than in most of the cities visited, advocates and providers were reluctant to attribute family homelessness to individual problems such as substance abuse and mental illness. In part, this reflects a dominant ideology among service providers of homelessness as a failure of the system. In addition, the decline in the economy and the escalation of housing costs have clearly put a larger portion of households at risk of homelessness. A survey of public attitudes towards the homeless indicated that 57 percent of respondents were sympathetic to the plight of homeless people because they felt that their own households were at risk of homelessness.¹¹

Many who call 1983–1987 the "good years" in the Massachusetts response to homelessness remember, sometimes with nostalgia, the collaboration and bonding that made things happen: encouragement to shape creative programs; the sense of hope that Massachusetts could indeed make a difference in its response to the moral tragedy of family homelessness. Reflection on those five years confronts us with their dark side. Already present in the good years were the seeds of demise, which left us vulnerable to the dismantling that occurred in the economic decline years.

The Economic Decline Years: 1988–1992

Family homelessness continued to escalate in the late 1980s. Shelters were full and the hotel/motel count reached its peak, with 684 families. Poor families were feeling

the strong effects of years of real estate speculation, decrease in real wages, and stagnation of welfare benefits.

Chronic poverty and public assistance alone do not characterize the homeless. Another population of families with at least one parent in full-time employment is now becoming homeless. This includes people from middle-class backgrounds, displaced by big rises in rents and condo-conversions, and with salaries too low to afford market rents. As in the case of the very poor, these "working homeless" are essentially no different from others of similar income who are still holding on to their homes, with increasing anxiety. The number of homeless families of this type becoming homeless will inevitably grow."¹²

This fear was verified by the experiences of formerly homeless women who declared that "two-parent, working families cannot buy homes and are struggling to avoid homelessness for the second time." Insightfully, they recognize that "anyone who lives near the poverty line is vulnerable [and] that group of people is getting bigger every day." Michael Stone in his study "One-Third of a Nation: A New Look at Housing Affordability in America" identifies a growing number of "shelter poor," those living on the verge of homelessness. His figures show that the number of U.S. households afflicted with "shelter poverty" rose from 18.7 million in 1970 to 26.5 million by 1987, a 42 percent increase.¹³

In the late eighties, when Governor Dukakis was campaigning in the presidential election, the state was confronted with increasing numbers of homeless persons. In 1983, in response to public pressure, the administration committed itself to an emergency response to homelessness, genuinely believing that the problem could be solved, without, however, "any fundamental reordering of society itself."¹⁴

But "emergency services are an unstable basis on which to ground policy. Claims are expected to disappear or diminish in intensity or institutions may be expected to routinize interventions."¹⁵ Homelessness did not disappear. Advocates witnessed the dismantling of the gains achieved in the boom years. A distressing shift began: control the numbers by restricting eligibility and multiplying regulations. This strategy of limiting access to shelter and housing was like putting a finger in the dike, court-jing short-term success and long-term disaster.

Limiting Access

Articles in this publication by Sue Marsh and Barbara Sard address in detail the dismantling of emergency policies, that is, Emergency Assistance (EA), which included emergency shelter and arrearage as well as access to Chapter 707, Section 8's, and other subsidized housing.

In the fall of 1989, the Department of Public Welfare implemented new regulations governing entrance into emergency shelter that restricted eligibility and required burdensome verification. It was a successful strategy. In fiscal 1989, 6,300 families received emergency shelter; in fiscal 1990, 4,700 families received emergency shelter, a 26 percent decrease in the midst of a serious economic recession.

Families who are currently homeless reported abuse from the welfare department in the form of misinformation and denial of services based on punitive regulations designed to reduce the number of families in shelter. Desperate families were often told that the state no longer provided shelter or that they were ineligible for help.

Families, unaware of their rights, believed what they heard. From January 1990 to June 1990, Greater Boston Legal Services received 190 cases of homeless families denied emergency shelter.

The Executive Office of Community Development regulated access to housing resources. Eligibility for 707 state subsidies was severely restricted. EOCD, as stated by an interviewee, "has helped to reinforce the worthy and nonworthy homeless message by adding a 'no-fault' element to HUD's [Housing and Urban Development] Section 8 resources. Admittedly in an effort to curtail the number of eligible homeless families, they defined specific categories of homelessness with stringent documentation requirements which did not formerly exist for federal housing resources." HUD has followed their lead with the creation of the Bootstrap Section 8 program, which ties housing subsidies to people who are involved in "self-improvement" as defined through the state's Education and Training program. Ironically, fewer people will be eligible for these as the state cuts back on EA and day care support for low-income families.

The action of the legislature also had an impact on the number of resources available for permanent housing. Chapter 707 state subsidies designated specifically for the homeless in the state budget were reduced by 60 percent in 1990 and then eliminated. The logical result is that families are destined to much longer shelter stays. In May 1988, a Project Hope resident could expect to live there for eight to twelve weeks. In May 1991, the length of stay, with luck, increased to eight months. The cost of this stay could house a family with a subsidy for four years.

Cuts were inevitable as the budget crisis worsened and the state had to face up to an economic recession. The rationale that supported these cuts was indeed disconcerting to many advocates who believed that we had moved beyond blaming the victim. "Homelessness faces U.S. [and Massachusetts] policy makers with a critical dilemma: they cannot actually 'solve' the problem, and yet they cannot ignore it. They must find a different approach. The government denies the extent of the problem, blames the victim, specializes the cause, and hides the consequences of homelessness."¹⁶

Factors That Influenced the Shift

Homelessness persisted beyond the point of patience for the politicians and the public. Complex socioeconomic causes permitted no easy solution. The cost would require major sacrifices for large numbers of people in the state. Effectively combating most social problems such as homelessness "requires large scale income redistribution attainable only through both higher taxes and higher transfer payments or subsidies."¹⁷ Citizens became conscious of this cost at the same time that Bill Weld campaigned for governor on a "no new taxes" and "elimination of government waste" platform.

Many were discouraged that after so much attention, homelessness did not go away, others were threatened by the presence of increased numbers of homeless people, and still others were just bored with the issue. These responses followed the pattern of the "issue attention cycle" in regard to domestic problems. "A problem suddenly leaps to prominence, remains there for a short time, and then, though still largely unresolved, gradually fades from the center of public attention, and then a new issue takes center stage."¹⁸

Frustration with homelessness and excessive budget cuts laid the groundwork for projecting the blame on the victim, a tenacious cultural perception that is embedded both in our psyches and social institutions. It was the most frequently stated rationale for the dismantling process.

This ideology expressed itself through a number of stereotypes: families become homeless to get subsidies; young parents want to get out from under parental control, so they have children, make themselves homeless, and access shelter and subsidies; families are homeless because of substance abuse, personal and familial dysfunction, and many of these are the hard-core multiproblem families.

These beliefs reinforced the idea that homelessness is a population, not a condition. While the state focused on limiting access to vitally needed resources, the federal government targeted grants to transitional housing, with a major funding focus on the cure and reform of homeless families. Such housing is based on the belief that families are not ready for housing and need long-range segregated housing to address their multiple problems.

This way of thinking reinforced a dual thrust in response to homeless families. First, there was an effort to punish families abusing the system by limiting access to shelter and curtailing subsidies. Second, there was emphasis on creating an alternative transitional program for the "cure" and "reform" of homeless families. We believe that both strategies are counterproductive. Keeping people in untenable and dangerous situations exacerbates problems, and shelter providers across the state are seeing the results of this effort. We see the dramatic increases in the protective services of the Department of Social Services, as well as the increased AFDC case-loads, as some of the fallout from lack of access to shelter.

Massachusetts advocates join several others throughout the country who believe that "transitional housing is creating another step in the parallel service system and that the longer that settings such as shelters and transitional housing are used to house families, the more they will be perceived as legitimate and 'normal' housing. While they acknowledge the need of families for support services, these experts advocate permanent housing scattered throughout the community and accompanied by a case plan for support services."¹⁹ This approach is based on the conviction among advocates that homeless families are similar to housed families. Both are in need of services. Physical and sexual abuse, drug abuse, failed education, and hunger are symptoms that reflect inequality and a puzzlingly high level of unalleviated distress in America, which is totally inconsistent with our proclaimed ideals and our enormous wealth.

Housed families in poverty and low-income neighborhoods and homeless families are equally victims of such distress. A Boston-area study compared fifty housed families to fifty homeless families in regard to prevalence of physical and sexual abuse. "Contrary to expectation, there were no differences between the homeless and housed women in their histories of sexual and physical abuse in childhood or adulthood except that a significantly higher proportion of housed mothers had experienced sexual abuse in adulthood."²⁰

Studies that described homeless families as problem laden, as distinguished from housed low-income families, have met with considerable resistance in Massachusetts. The advocacy community believes that such studies give credence to the exceptionalist approach to homelessness and lend a veneer of validity to the blame-the-victim mentality.²¹

Public Backlash

Marshall McLuhan pointed out that it is the American public that manages the news by either maintaining or losing interest in a given issue. In the boom years, when there was intense interest in homelessness, human service providers and advocates were continually barraged by the press, particularly during the holidays. In the years of economic decline the reverse became true. They refer to a media blackout, or backlash. "From Atlanta to New York, from Washington to Philadelphia, there is a backlash against those who live in the street. In some cities police are cracking down, in others funding for shelters is drying up. The homeless who once could count on a greater degree of society's compassion, are now the victims of its 'compassion fatigue.'"²²

During a meeting at the Boston Foundation, advocates and human service providers addressed the backlash issue. Charlotte Ryan, a media consultant with Boston College Media Research Action Project, reviewed several articles in the national press and identified key themes. Some of these flow from blaming the victim: the homeless are not the deserving poor; the homeless are so by choice; homeless people are drug addicts and alcoholics; taxes for government programs are going into a black hole; and homelessness is an unsolvable problem.

In the early years the homeless were viewed with compassion: the energy of society flowed naturally toward finding a solution for their suffering. Now that they are subconsciously or consciously labeled as undeserving, the public feels justified in moving on to other agendas.

Our reflections on the collective learning and wisdom of those interviewed lead us to the following conclusions:

- Public servants who had been advocates and close to the grassroots experience facilitated communication, dialogue, and bonding among actors in state government and the advocacy community during the economic boom years. These linkages favored a systemic response to family homelessness.
- Advocacy groups — Massachusetts Coalition for the Homeless, Greater Boston Legal Services, Committee for Basic Human Needs, Massachusetts Law Reform, Massachusetts Shelter Providers Association, as well as the Fund for the Homeless, which frequently convened joint strategy sessions — worked together around a focused agenda. Their collaboration helped to focus the response in the economic boom years toward access to shelter and housing subsidy, as well as to coalesce these actors to prevent splitting and further reductions in the economic decline years.
- One of the most significant lessons was the definition of family homelessness as an emergency necessitating a crisis-oriented response. The Dukakis administration was under pressure to solve this problem that confronted the public conscience. And because advocates tend to focus on winnable fights, these two needs converged and the focus was to create a humane model, in contrast to a barracks-type model, of family shelter. Only as key actors lived this response did the need for accessing subsidies for permanent housing become the main

focus. Often the extent and emergency of people's needs impede advocates from the kind of research and analysis that would call for long-range public policy changes.

- When the situation of families living in cars, on streets, and in unsafe doubled-up situations became known, it shocked the moral conscience of Massachusetts citizens. Instead of blaming the victim, advocates and government officials linked with the press to educate the public to the need for affordable housing to decrease homelessness.
- Advocates expressed regret that the academic community was largely absent from the debate. "Where were the universities?" "Where were the schools of social work?" Early on, a conceptualization of homelessness called for vigorous housing policies and dramatic increases in welfare, and advocates believed that the academic community would have been a great asset in realizing that aim. If they had entered the picture, we might have avoided the creation of a shelter industry. One interviewee who was significantly involved in shaping the state's policy said, "If I had to live those days over, I would focus on sufficient income for a family to do more than survive, the need for subsidized housing, child care, education, and training. As a middle-income woman, I need all of the above for my family." Advocates need to tackle systemic changes, with an eye to long-range results.
- Unlike those of other states, the Massachusetts advocate community was well organized. Homeless people appeared at protests, rallies, and meetings through the intervention of advocates and human service providers, but they were not organized as a distinct group. Advocates affirm the need for homeless people to express their own requirements and capabilities as a great corrective to the internalization of blaming the victim and the human service provider community. Insights from the homeless can challenge us to acknowledge our own participation in injustice and help us to avoid becoming co-opted and part of the problem.
- Homeless families and poor families in low-income neighborhoods are much alike. We should have forged bonds between the homeless, the AFDC, and low-income communities. Together we could have developed a comprehensive strategy for poor families in general. We could have been more supportive of Education and Training and the links to jobs, skills, and day care.
- We must stand inside the experiences and neighborhoods of the economically disenfranchised if we are to undergo a conversion of perception and see the world with new eyes. A challenge is presented to us by John McKnight, who suggests that we "need to develop a capacity-oriented strategy in needs assessments, rather than deficit-oriented strategies. We need to recognize the nature of the human assets, skills, and abilities that exist in low-income neighborhoods. People and neighborhoods cannot be built upon a deficiency orientation. Policies, programs, and resources predicated upon deficiencies are the cornerstones of dependency, consumption, and clienthood."²³

- Last, we must continue to believe that homelessness can be solved. "You don't have to be mean-spirited to walk away from social problems. All it takes is the certainty that nothing can be done to solve them."²⁴

The economic boom years favored a systemic response to family homelessness. When the emergency did not go away, and the budget crisis worsened in the years of economic decline, we lived through a painful dismantling of the gains of the boom years. What was most disconcerting was the shift from problem of family homelessness to that of problem families who are homeless — at both state and federal levels. "For if it is the character faults or pathology of the poor that best accounts for their poverty, then the deeper systemic questions that their disturbing presence might otherwise provoke may be safely ignored."²⁵

The moral tragedy of homelessness, of poverty, lies not only in the fundamental inequities in the economic, social, and political fabric of U.S. society, but in the cultural disparagement that accompanies them, the denial of human dignity. The cultural dynamic of blaming the victim "has its most tragic effect when the targeted group, without adequate resources for sustained resistance, accepts and interiorizes and acts out the denigrating verdict. The tragedy is that people under pressure, out of touch with their true power, will live down to the image of themselves projected with such force by the dominant culture"²⁶

The challenge that faces Massachusetts and the nation is to address this fundamental norm in judging and crafting public policy: "What will this approach or policy do to the poor and deprived members of the human community?"²⁷ 28

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Circle

Dean Hamlin

The night is cold and empty,
The rain is only wet;
My breath is only moving air,
My life is like a debt.

My skin is like the sidewalk,
My eyes are only here;
The darkness that surrounds me
Seems neither far nor near.

Why do I wait for something
When nothing's all that comes;
Why do I wander Main Street
And meander through the slums?

"I live, is all," I say aloud,
With no abrupt reward.
The murky sky ignores my cry;
The street pays no accord.

Failure looms before me
And taunts me from the past;
I don't believe in destiny,
But that what's cast is cast.

"I live," I cry aloud again,
Yet what do such words mean;
When relief means not desiring,
And to be means having been?

I decide to die a thousand times,
And fail to find a way;
And only see that the world
Is growing older every day.

When sleep means only waking
To find another day,
With no place left to go,
And no place left to stay.

When memories are torture
And future means "go on,"
And the steel and concrete world
Will feel no difference when you're
gone.

The night is cold and empty,
The rain is only wet;
My breath is only moving air,
And my life is like a debt.

Dean Hamlin is a member of the Portland (Maine) Coalition for the Psychiatrically Disabled. His poem first appeared in Pile of Papers; Stack of Karma, a collection of poetry published by the Portland Coalition Press. Reprinted with permission.

Down and Out in Boston

Jack Thomas

As shadows of the winter night draw near, Rubbish and I leave Emilio's on Tremont Street where he has been describing, over black coffee, how his addiction to booze has cost him his job and his family and has knocked him overboard into the abyss we call homelessness.

Braced against a bitter wind and an icy rain that has blackened streets, we head north on Tremont and then east along Milford, passing gentrified brownstones and chatting as we sidestep the puddles that polka-dot the brick sidewalk.

Suddenly, Rubbish stops.

"I gotta take a leak," he says. "Cover my back."

Unsure as to my responsibilities as lookout, I glance up and down Milford Street, grateful to see there are no other witnesses as Rubbish slips into the alley at 4-A Milford and urinates against the brick wall of someone's home, describing at the same time the decadence of Boston's shelters for the homeless, especially Pine Street Inn.

"It's a [expletive] nightmare," he says from the alley. "I'd rather sleep in the banks. You go to Pine Street, and you'll see hell on [expletive] earth. A lot of guys don't go near shelters 'cause you need a [expletive] Thompson machine gun to get through the neighborhood, and you get bullied . . . and the shelters are depressing and dangerous. You can get crabs there or lice or [expletive] scabies or whatever. And alcohol attacks the lungs, so in the morning, everybody's got the dry heaves and is trying to throw up, or not throw up, 'cause 70 percent of the people there are alcoholics, and the rest are coke freaks who take advantage of the drunks when they're down and out. If you want a bed, you gotta get there by four o'clock in the afternoon and that means you end up going out of your [expletive] mind sitting around with nothing to do, and everybody belching and puking.

"The shelters suck," he says, emerging from the alley and zipping his trousers as we head east.

"At Pine Street, there could be a tuberculosis epidemic in the bathroom. Not that it smells like a pissy barroom, but it's like you're walking into a cloud of chloroform pneumonia gas or something, and it's disgusting. And your life expectancy? Terrible. If you watch *National Geographic*, what a lion does is pick out the weakest, and

Jack Thomas is a reporter for the Boston Globe, in which this article first appeared, on February 12, 1992. Reprinted with permission.

that's what happens at shelters. Behind Fort Point [shelter] there's the channel, and I know a guy who had no family or nothin', and he drowned in it. They said he had a seizure, but I know he got [expletive] pushed, but nobody asked any questions, 'cause it's not like [expletive] John F. Kennedy fell into the river and died.

"Now stay out of this neighborhood at night," he says along Shawmut Avenue, "and over there," he says, pointing his cane toward Peter's Park. "Stay out of there day or night 'cause it's a [expletive] war zone, and if you want cheap clothes and style ain't important," he says, directing his cane toward Harry the Greek's, "that's where hoboes buy their clothes."

We are in the heart of Skid Row, at Washington and Dover Street, or East Berkeley, as it's been renamed in an effort to disguise the fact that for decades it's been the main drag of Boston's bowery, a nether world where bums and beggars wander streets that lead nowhere, occasionally seeking refuge in doorways to avoid the ill winds that always blow in Skid Row.

Trudging along Dover, a block from Pine Street Inn, we come upon an old black man sitting on the curb in an alcoholic stupor and staring into the hubcap of a 1984 Nissan. Despite the freezing rain, he is wearing no hat and no coat, and he is malnourished and emaciated and shivering badly.

"How're ya doing, old-timer?" says Rubbish, leaning down.

"I'm cold, man," he says, shaking violently. "I'm jes' [expletive] cold."

We lift him out of the gutter. He weighs, perhaps, 120 pounds, and he hangs suspended between us for a moment, unable to straighten his legs because he is so cold.

"An' I los' my [expletive] hat, man."

From the gutter, I pluck his black stocking hat, which is heavy with rain and stained with phlegm.

"Drop it, man," says Rubbish. "We gotta get 'im inside."

"I'm so [expletive] cold, man. I'm gonna git pneumonia."

We loop his bony arms over our shoulders. His teeth are chattering and his head shaking from the effects of alcohol and icy rain. As we head toward Pine Street, pedestrians make a swath to avoid contact with three men who are unshaven and unkempt and staggering along, ragged, dank, and malodorous.

"You're in good hands with Allstate," says Rubbish, in a feeble effort at humor.

The drunk glares at him.

"You sound like [expletive] Mutual of Omaha."

Turning onto Harrison Avenue, the old man's knee slips to the pavement as Rubbish stumbles, having gagged from the nauseating stench of dirty clothes, body odor, rain, and whiskey.

"They gotta give me a hat," says the drunk. "I know they will. And they gotta take me in. I'm so [expletive] cold, I'm automatic."

As we round the corner and head up the alley, the door to Pine Street Inn is thrown open, and out rushes an aide with a wheelchair to rescue another drunk passed out in a puddle atop his crutches under a sign that says, "Pine Street Inn." Down the alley, an old white man ignores the fuss, tilts back his head, and, through a cloth, filters into his mouth the contents of a twelve-ounce plastic container with a Citgo label. It is $\text{CH}_3\text{-OH}$, methanol, or wood alcohol, otherwise known as dry gas.

The Pine Street Inn is where Boston warehouses its homeless, including chronic alcoholics, drug addicts, and mentally ill people whose "deinstitutionalization" has saved millions for taxpayers. With the mental health budget having been reduced by

\$50 million, Pine Street now provides beds for 763 people a night, or 39 percent of the shelter beds in Boston, and an overwhelmed staff is struggling to cope with what amounts to the state's largest de facto mental institution.

Upon entering, the three of us are frisked for drugs and weapons, a search that fails to uncover an eight-inch knife given to me by a friend who knows the dangers of the street.

To the left and right are rooms the size of a school cafeteria that are reminiscent of Dickens novels depicting the institutional degradation of the poor in nineteenth-century London.

In the men's room, the air is fetid and the floor and walls are filthy. In the common rooms are more than a hundred men in dank clothing who are not used to shaving every day, nor every other day, and while a few play checkers, most sit along the walls with hands folded in their laps, staring straight ahead. Some are engaged in animated conversations with themselves. Many more have passed out or fallen asleep on tables, chairs, benches, and bare floor.

Pinned to the wall are leaflets, urging men to sign up for a talent program called the Gong Show. On the floor, the water trickling into a drain is stained with blood, and a resident cautions not to step in toxic waste. A man on crutches decides it's easier to urinate in his trousers than struggle to the men's room. Another is puking into a paper cup.

A moment later, yet another old man, seated with his hands in his pockets, passes out and falls forward, his head hitting the floor like a melon, his brow splitting severely enough to require medical attention. Within three hours, because of injuries or fights, two ambulances are called as are two police cars. Amid the chaos, in a corner near the door sits a small, old man who has passed out in a sitting position, wearing a jacket that says "Jamaica Plain."

This Way Down

There's no way to prepare for a week on Skid Row.

There's no way to condition your taste buds for the stale baloney sandwiches, no way to fortify yourself for the insults while panhandling at Copley Square, and no way to compose yourself for the ever-present racial hostility that boils to the surface at mealtime and in the showers at Pine Street Inn and on the long and sullen and mostly silent bus ride to the Long Island Shelter. There's no way to inoculate yourself against the risk of disease while living among men whose hacking coughs break the stillness of night. And there's no way to inure yourself to the constant threat of violence or the erratic behavior of someone like Quiet Man, who is convinced he hears the Chinese burrowing through Earth to Boston, which is why he wanders into the Red Line from time to time to alert commuters that the station is about to collapse because the Chinese are getting close.

Living inconspicuously among the homeless for a week is easy if you don't cut your hair for two months and you don't shave for ten days and you dress in a tattered German field jacket. By the third day, I looked so down and out commuters averted their eyes, old friends failed to recognize me, and at Faneuil Hall, as I walked by a table, a woman clutched her purse. A cashier at Dunkin' Donuts accepted a dollar bill from me with thumb and forefinger, convinced it was contagious, and an old bum panhandling on Essex Street greeted me like a fellow traveler. "Hi, buddy," he said, without asking for change.

A census in December counted 3,893 homeless people in Boston. Half are single men, 37 percent are families, and 12 percent single women, according to a study by the National Conference of Mayors, and 48 percent are black, 23 percent are veterans, 40 percent are addicted to drugs, and 29 percent are mentally ill.

However difficult life on the street is for men, it is worse for women. As Kathleen Hirsch pointed out in *Songs from the Alley*, her highly praised book about life on the streets of Boston, while men are accustomed to banding together and learning to survive in the military service and on jobs requiring physical labor and even in prison, women who live in the open and lack such experience are far more likely to be victims of assault, robbery, and rape. A rape crisis center reported recently that a homeless woman staggered in after midnight, having been raped twice within several hours by different men in different parts of the city.

At a time when government assistance to the poor has been cruelly reduced, what has kept many homeless people alive is an army of men and women of conscience who donate money and also time every week at shelters and at soup kitchens. At the Church of the Advent and at Saint John the Evangelist in particular, volunteers serving meals to the hungry and homeless do so, even in the face of rudeness, with relentless good will.

Homeless men survey the shelters for a place to live the way the rest of us survey the cities and suburbs. Just as Hingham is more attractive because of the seacoast, so is the Long Island Shelter, and just as Lincoln is more appealing for its safety, so, too, is the gospel mission house on Kingston Street, and just as slum housing, for some, is the only option, so, too, in the world of shelters, a night at Pine Street Inn is the last stop.

Only a fool would underestimate the dangers. At Fort Point Shelter, favored by younger alcoholics, or nouveau drunks, as they are called, a young black man, handsome and articulate and once a high school coach, lifted his head from the table where he had been sleeping in the middle of the day and said, slowly, "This place is literally, *literally* a madhouse."

Unable to endure the threats of violence and racism and disease at shelters, some men choose equally dangerous accommodations, like the heated grilles adjacent to Boston Public Library. At Charlesgate East, under the highway from Park to Storrow Drive, a man has made a home of space under the bridge. With the roar of traffic a few inches over his head, he sleeps on a makeshift mattress along the girder, about five feet off the ground, in a sleeping bag with army blanket. Along the beam, over his head, are kitchen utensils, candles, mirrors, three boxes of Chinese food "to go," and his only concession to "art," a *Playboy* centerfold.

It is a mistake to generalize about urban hoboes, for while three out of ten are mentally ill, it is not uncommon to hear conversations about French cuisine or the Israeli economy, and many of the homeless are fascinating characters, like Beret, a chef and gentleman, and Blondie, his pal from New York, and the Snorer, who slept in a bunk above me at the mission house in the Combat Zone, and Hiawatha, the Latin American with an American-Indian haircut, and Funny Man, the entertaining beggar, and Notre Dame, who knows everybody if not everything, and Mary Book-keeper, who's off to Phoenix, and Quiet Man, and Orange Hat, who plays piano like Thelonious Monk, and Mountain Dew, the kindly alcoholic from Lexington, and Rubbish, who scavenges alleys and plays classical guitar.

Funny Man's Man

Among the most entertaining panhandlers in Boston is Funny Man, a slender, quick-witted black guy who can be found many mornings at the Park Street kiosk, where he and I are greeting commuters as they climb the stairs from the Red and Green lines.

From a local shelter where he sleeps, Funny Man makes his way to the kiosk by 6:30 and stays four hours. Once a trolley arrives, and as commuters ascend, Funny Man moves side to side, sizing up prospects as to which are generous, which stingy.

Dressed in black stocking cap and clothes that make it clear he is a man of the streets, Funny Man's only tool, in addition to banter, is a plastic cup from McDonald's in which he keeps several coins that he shakes like castanets.

His repertoire is a finely tuned, well choreographed monologue of political wit, social observation, weather updates, and old-fashioned hustle.

As a well-dressed gentleman climbs the stairs, Funny Man approaches, shaking the coins, and, with split-second timing, he dips his left knee so Mr. Commuter cannot miss the cup.

"Muh MA-A-A-N," says Funny Man.

Resigned, the gentleman drops fifty cents into the cup. Funny Man dips his knee even deeper, smiles, and, by way of thanks, says with even greater emphasis, "Muh MAAA-A-I-N Man."

Most commuters climb the stairs with head down, trying to ignore Funny Man, and many others glower, for it is annoying to give a beggar money, as Nietzsche observed, and annoying not to.

"No spare change," says a white man, who strides out the door to Boston Common, letting in a blast of frigid wind and a swirl of crisp oak leaves.

"Den, how 'bout a buck for luck?" yells Funny Man.

"My MA-A-A-N's coming," says Funny Man to a student who walks by.

To a man in a \$400 camel overcoat, "Hey, dude?"

Camel Coat glares and then marches out the door.

Funny Man smiles.

"He looked at me like I was stupid."

Jiggling coins at the approach of a schoolgirl, Funny Man says, "Can you see it in your heart to help a homeless man?"

"No thanks," she says, passing out to Boston Common.

Funny Man looks at me, startled.

"She act like I'm 'posed to be giving *her* change," he says.

"Button up, pretty lady, it's cold out there," he urges a young woman who buys a *Globe* for thirty-five cents, after which she turns and gives the fifteen cents change to Funny Man.

"Thank you, pretty lady," he says.

"Now that," says news dealer Robert Siegel, "that's what drives me crazy. I mean, why wouldn't she give me the fifteen cents? It's like a knife in the heart."

It's also an irony of the street that Siegel, who has a job, doesn't earn as much money as Funny Man, who has no job — proof, perhaps, that Charles Lamb was right, that beggars are the only free souls in the universe.

Shelter and Devotion

At Kingston House, a gospel mission at the edge of Chinatown and the Combat Zone, it is 7:30, and about seventy-five men are awaiting breakfast, but not a morsel will pass anyone's lips until Brother Cornelio Lopez delivers his morning devotion.

It's a good deal for everybody. Hungry men are assured a breakfast, Brother Lopez a congregation. Out of courtesy, some remain awake through his sermon, although it is impossible to determine among bowed heads who is praying, who has nodded off.

A lot of these men, as Brother Lopez observes in his Sunday sermon, "don' even know they on erf." It takes a moment for his congregation to realize that he is talking about the planet "erf."

Once a street person himself, Brother Lopez is popular among the men, although he runs a tight ship that permits, as he puts it, no alcohol, no drugs, no cussin', and no pornographies.

"I know you here to get out of the cold," says Brother Lopez, leaning on the Hitachi television, "but I hope you also here for the devotion, right? Amen. And so, we not tired and sleepy and we not gonna read the newspaper, amen?"

A few men mutter "amen."

"Good to see all of ya here, amen, praise the Lord."

After prayer, and with accompaniment from an elderly gentleman at the upright piano, Brother Lopez leads in singing Hymn 202, "Love Lifted Me," a rendition remarkable in that not one man ever hits a proper note, not even accidentally.

For a congregation of men who have struggled with alcoholism, the title Brother Lopez has chosen for his sermon is an ironic one, "Sour Grapes," except that what Brother Lopez is addressing is jealousy. After reciting a scripture from Peter, Brother Lopez reads from a pamphlet about jealousy that includes reference to a sixty-nine-carat diamond in the window of a Fifth Avenue jeweler — and here, he stumbles.

"Carta . . . Cartara . . ."

There is a pause.

"Cartier's?" yells Blondie, who grew up in a well-to-do family in New York.

Startled that a homeless brother can identify a Fifth Avenue jeweler, the men look to Brother Lopez, anticipating his wrath.

"Gimme that name agin?"

Blondie hesitates.

"Cartier?" he says, this time in a soft voice.

"Thank you very much."

"I'm sorry," says Blondie.

"No, ah 'preciate that. If I pronounced it wrong, I stand to be corrected. Never get to the place where you think you can't be corrected, amen? They's something wrong wit' you if you know it all and you don't, amen? That's why I axed the question."

Brother Lopez continues.

"The huge diamond was displayed in the window of . . . What's that word again?"

"Cartier's," yell five or six men.

"Right, Cartier's. Must be mah Southern accent, amen?"

For the rest of the sermon, the men are attentive. By his humility, Brother Lopez has won, if not their souls, at least their respect.

Everyone Is John Doe

On the street, where anonymity reigns, everybody is John Doe, and everybody lives where he slept last night, and his Social Security number is the first nine digits that come to mind.

At Long Island Shelter, it is an hour before “lights out” and Blondie is stretched out on his bunk when his name is called over the loudspeaker, advising him to report to the office for counseling in getting a job and straightening out his life.

The conference begins with a warning.

“I’m a vocation counselor at a college in Boston,” the adviser says, “so you can’t [expletive] me.”

Blondie nods obediently, then gives the adviser a fake name, fake address, fake date of birth, fake age, and fake Social Security number, and swears that he never uses drugs, never drinks, and is diligent about looking for work. When the session is complete, they shake hands, and the counselor thanks Blondie for his forthrightness.

A Degree in Hustling

Meet Beret, a courtly gentleman with degrees from Harvard Extension School and from a culinary institute in France. Having grown up in a family that owned a Boston restaurant, in years gone by, Beret used to deliver day-old food to Saint Francis House, a soup kitchen in the Combat Zone.

Now, he lives there.

“This is embarrassing. I’ve never been arrested, never do drugs, always worked hard, and always paid the bills, but I’ll tell you, if this can happen to me, it can happen to you.”

Beret had been chef for eight years at an exclusive Beacon Hill club for women until it closed in 1989, giving employees four days’ notice, no severance.

Unable to find work in Boston, Beret headed for Key West, and because he’d been educated in Europe and had a commendable record, he assumed he’d have no problem finding a job.

On the bus to Key West, however, an elderly woman pickpocketed seven people, including Beret, from whose knapsack she filched \$4,800. “I called home,” says Beret, thirty-seven, “but my mother decided this would be a good learning experience.”

It has been.

Now he’s got a degree in how to hustle.

“If you’re carrying a backpack, people trade advice about the scams, how to file for food stamps or welfare, how to get a crazy check, which in Florida means if you act crazy and live in the street, they give you like \$680 a month. There are people who make a living this way. They live in shelters and the weather’s perfect, and to them, that’s a wonderful life. And because they eat at soup kitchens, they can sell their food stamps for fifty cents on the dollar.”

What Beret wanted, however, was not charity, but work.

“After a few days camping out, though, you *look* like you’re camping out, and that gets negative responses from employers.”

And so he spent his first Thanksgiving Day away from his family, although eating turkey dinner at a soup kitchen with drunks and drug addicts took a toll on his psyche.

"It hit me internally. When I ran out of the pocket change I had, I found myself in a soup line, and coming from a family that never went without, it was degrading."

He met a pal, Blondie. They hitched to Miami and slept under Interstate 395. Still unable to find work, they walked forty miles and slept at a Salvation Army in Fort Lauderdale, where there were no jobs, either, except dishwashing at \$3.85 an hour, and even then there were thirty Haitians ahead of them. Hopping freight trains and conning their way aboard buses, they made it to Boston, where Blondie and Beret now eat at soup kitchens and sleep at shelters and hope for a job.

"I'm embarrassed," says Beret. "I come from a hard-working family. Dad graduated from MIT, developed two electronic businesses, and Mom lives off the interest. She thinks I got a little too much when I was young and wants to see me take care of this on my own, and if I stumble, I suppose she'll be there, but I guess she's decided she'd rather I work this out myself."

A few days later, Beret reports to a dental clinic for free care. Told he must have a tooth extracted, Beret alerts the dentist that his jaw had been broken and that there are pins near the tooth. "No problem," says the dentist. "We'll twist the tooth the other way."

Unfortunately, however, the dentist reversed the negative and in performing the extraction, he twisted the tooth the wrong way, breaking Beret's jaw once again and forcing him to spend three days recuperating at Boston City Hospital.

Treasures in the Trash

"Step into my office," says Rubbish, as we turn off Arlington Street to scavenge trash barrels in the Back Bay along an eight-block alley that runs from Arlington Street to Massachusetts Avenue between Beacon and Marlborough streets.

He's thirty-five, has a salt-and-pepper beard, plays classical guitar, adopted Timothy Leary as his boyhood hero, and once earned \$200 a day repairing Porsches, until alcoholism got the better of him, and he lost everything and took to the streets seven years ago. Sober for six days, Rubbish is staying at a Salvation Army shelter, awaiting a bed at a treatment center.

"Sometimes, I luck out," he says, heading for trash cans in back of a Marlborough Street brownstone. "I go into what I call ritzy alleys and you'd be amazed at what people throw away. If I owned a house, I'd never buy furniture, honest to God, 'cause people throw away beautiful mahogany stuff. I've found Frye boots, Mexican artifacts. Once I found three rolls of dimes. There are days when these alleys are like Filene's Basement."

At the rear of a Beacon Street apartment he spots a Franklin stove and, nearby, a butcher-block table, and ponders whether to hide them and return later for them.

"I use this stick," he says, referring to his cane, "so I don't have to get my hands filthy. Plus, if I run into the wrong guy, it's hard cherry so I can rap 'im over the head." His only other tool, besides his wits, is a razor to slit plastic bags.

At No. 216 Marlborough, he finds silver rings.

"A stewardess lives here," he says, poking among bobby pins and barrettes. "I can tell by the type of stuff she's been throwing away."

Back and forth across the alley he zigs and zags, lifting lids and slitting bags and then probing with his cane.

"You heard of people, like, throwing stuff away with the trash? I've found dollar bills, \$15 once, \$17 another time. I got the shock of my life once when I opened up a can and what do you think is looking up at me? A [expletive] rat!"

As he works, he philosophizes about life in the streets.

"I used to live in Brattleboro, which was so [expletive] boring that one night I fell asleep in a movie and nobody woke me up. That's how boring it was, so I stayed all night till morning when the liquor store opened across the street.

"The economy? Well, it's a complex issue, but basically, I think it sucks. It's the rich protecting their interests at the expense of the poor. And Weld? Born with a silver spoon in his mouth. Got no freakin' idea what it's like to be poor."

Rubbish decides to pass up a dozen albums by Lionel Richie and Tina Turner, then takes a break, slipping between a Saab and a Nissan XE to urinate against a tire.

"One day I was going through a barrel — you won't believe this — and I found, from Pier 1 Imports, a bag of brass bells from India. I guess you use them to call your cat, and I tried to sell 'em on Newbury Street, at a Tibetan place, but he wants handmade stuff. So I ended up bringing 'em back to Pier 1, and guess what? They gave me a store credit, 367 bucks."

Before alcoholism kicked in when he was eighteen, Rubbish had practiced classical guitar three hours a day. "Just scales," he says, peering into a barrel, "and then I'd study a piece, like Etude in B minor by Bach, transposed from piano to guitar."

For all its grubbiness, scavenging, at least among street people, is more prestigious, or more accurately, not as disreputable, as collecting cans, or canning, as it's called.

"What I'm going for is junk, 'cause that's where the money is, aluminum, brass, copper," says Rubbish. "But if I have to start pushing a freakin' supermarket carriage, well, I just ain't gonna do it. I just ain't going [expletive] canning."

At Long Island Shelter, at dinner, the men are wondering why a woman would be homeless, that is, why she would not use her wiles, somehow, to save herself the humiliation of the street. "At the very least," says Notre Dame, "she could marry an Air Force lieutenant. They're stupid."

At a nearby table, Cat Woman, so named because she feeds wild animals, is singing hymns and reading from tracts in an effort to convert a homeless man to the Seventh-Day Adventist church.

"See that guy two tables down in the red shirt," says Notre Dame. "He was thrown out of Kingston House."

For what? someone wants to know.

"For masturbating," says Notre Dame.

"As if no one else did it," says Beret.

Upstairs, there's not much intimacy to the sleeping accommodations. It's a room with 132 beds divided into groups of four, each group separated by four-foot walls freshly painted blue with red trim. Each man gets a cot, a pillow, two sheets, and one blanket, or two, if you can con the supply man, which Beret and I succeed in doing.

"Thank you," Beret and I say, and from the half dozen Latin guys in line in back of us, there is a snicker and snide remarks about the dumb white guys who say "thank you."

The next morning, it is still dark when the bus clammers along the coast of Long Island, and with the ever-present racial tensions no one talks till we reach Quincy Shore Drive, when Beret, who is white, shifts in his seat and allows his coat to brush against a sullen black man.

"Don't touch me again, man," he says in a threatening voice.

"It's clean," says Beret.

"You don't understand," says the black man bitterly. "I don't want you to touch me at all, no way, no how, understand?"

It is the last conversation until the bus arrives at dawn at Albany Street.

On Tuesday night, before the doors open to the soup kitchen at Church of the Advent, there are sixty people shivering in the darkness along Brimmer Street, including Mary, Mary Bookkeeper, who has lost her job, can't find another, and is off to Phoenix tomorrow by bus for a new life.

"It's easy to get discouraged. When I went to apply for a job as a teller, do you know how many were ahead of me? One hundred and thirteen!"

Over a soup-kitchen supper of pasta and ham, she confesses that she doesn't have a college degree. "But look at the way the banks are folding. They're all run by college graduates, so what good is it?"

She is alternately streetwise and naive. She says, for example, that it is bad for homeless people to sleep on the vents outside the public library because, among other reasons, they roast on one side and freeze on the other. A moment later, however, she looks at a man from Pine Street Inn and says, "Is it true that everybody at the shelters is pickled?"

When conversation turns to politics, her voice hardens in the bitterness many homeless people feel toward President Bush.

"His middle name," she says, "is asinine."

Before departing, Mary carefully counts from her purse a dollar in coins to drop into the can as donation for dinner, and then, assuming that no one is watching, she takes a roll of bread, wraps it in a napkin, and places it in her purse for tomorrow's long ride to Phoenix and her new life.

Having spent last night outdoors at the Brookline Village T stop in temperatures below 10 degrees, Mountain Dew, a twenty-seven-year-old alcoholic, is as down and out as it gets around Boston. He is tall, handsome, and mannerly, and, if you catch him sober, he is articulate enough to explain why he is an alcoholic.

"I blame Nancy Reagan," he says, sitting in a Tremont Street coffee shop, unable to stop shivering.

As the son of a well-to-do family in Lexington, Mountain Dew is baffled himself by his misfortunes.

"How did this happen? I can't figure it. I've got four older brothers and sisters, all college graduates. But I got thrown out of junior high, so they sent me to private school, Saint Sebastian's Country Day, but they threw me out, too, 'cause we got caught destroying a couple of schools. Extreme aggression towards schoolhouses, they called it."

The slide began early, when he was about eleven and started using marijuana, then, as the years passed, coke, LSD, and heroin. "And if it wasn't available in Lexington, it was a short ride to Adams Street, Lowell, where you can get anything."

As we talk, he shivers, not yet having recovered from his night of pacing the Brookline Village T stop, and he turns aside admonitions that he needs rest.

"I can get by on two or three hours' sleep a night."

Although it is not yet eleven, he has already bought the day's bottle of befuddlement, a pint of vodka and Mountain Dew chaser.

Why not a fifth of vodka, or a quart?

"Too dangerous," says Mountain Dew. "I might pass out and freeze to death."

Having lost his job at a printing plant because of alcoholism, Mountain Dew's been living on the streets two years, and survives on SSI payments he's been receiving since a motorcycle accident in 1985.

His last attempt to find work is a bitter memory.

"It was about eight months ago, on Brookline Avenue. They were looking for a garage attendant, and when I got there, there were fifty people in line, old ladies, guys in three-piece suits who looked like they just walked out of the stock exchange. They had 250 applications altogether. Can you believe it? All for a chance to suck exhaust fumes all day."

Despite the warmth of the coffee shop, Mountain Dew shivers as he describes the pain he gets near his liver when he drinks too much, and then, suddenly, he turns the tables and instead of answering questions, he asks one.

"Why are you writing this story?"

"I don't know. I think governments in Washington and in Massachusetts have abandoned the poor. I don't know whether it's because they don't know what to do, or whether they don't care. A lot of us drive by shelters or walk by homeless people without seeing them. And the numbers are growing so fast, we're becoming numb, and we can't seem to agree on what a society owes its own people when they're down and out. I thought that maybe if the homeless were written about as people instead of abstract numbers, well, it might make a difference."

Mountain Dew thought about that. He sipped his soda, took a long drag of his Raleigh Extra, and then blew the smoke into the air. Finally, staring at me through bloodshot eyes, he shook his head, and said, "It would take an act of God." ☹️

Making the Homeless Disappear

Redefining Homelessness in Massachusetts

Sue Marsh

While unemployment rocked Massachusetts, housing costs remained at record levels, and the federal government continued its inattention to housing and human service programs, the numbers of homeless families sheltered by the commonwealth of Massachusetts declined. This article examines the changes over the last decade in the way Massachusetts provides shelter to homeless families. What has in fact changed for homeless families, Marsh contends, is whether the state of Massachusetts considers them homeless. An increasingly complicated and burdensome set of rules has become a highly effective gatekeeper that keeps the commonwealth's shelter expenditures down and homeless families out.

Counting the homeless has served a variety of functions for the past decade. Indeed, the politics of counting are so complex, the Federal National Mortgage Association (Fannie Mae) Annual Housing Conference of 1991 dealt exclusively with the issue, inviting a range of scholars, policymakers, and advocates to write and speak about this topic. The controversial aspects of counting cropped up again in the context of the 1990 census, as officials and homeless advocates contested one another's methodologies, premises, and results. Indeed, census taking has become as essential a part of homelessness policy as shelter, affordable housing development, and service delivery.

A key difficulty in counting homeless people is the very nature of their circumstances. Homeless persons are transient — they lack a permanent place to live. “A count of the homeless always reflects only those who have been observed, identified, or otherwise estimated. But a hidden population [such as the homeless], by definition, also contains members who remain uncounted and unknown.”¹ Clouding the accuracy of such counts are, at a minimum, issues of definition, of timing, and of accessibility.

Who “counts” as a homeless person varies according to perspective. During a Massachusetts Coalition for the Homeless (MCH)² campaign to create a preference for homeless persons for state housing resources, a group of housing and redevelopment officials offered the position that only those without shelter *of any kind* should be considered homeless.³ This position precludes even those living in cars from

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being defined as homeless. (Commonwealth officials rejected this argument.) Most frequently, it is the decision to include households living in overcrowded and sub-standard conditions as homeless that sparks disagreement. Anna Kondratas, a staff member of the U.S. Department of Housing and Urban Development, discounts these groups as legitimately homeless⁴ and contends that only those found on the streets or in emergency shelters should be so considered. Providers, legal aid attorneys, and advocates who work with households in these circumstances assert, however, that given the tenuous living conditions in which these families live, they are rightly considered without safe and secure housing. In any event, the lack of consensus — even in terms of defining whom to count — makes surveys that much more difficult.

Homeless families and individuals are without housing for various lengths of time. In Massachusetts, the average length of homelessness for families has ranged from sixty days (in 1990) to the current five to six months. For individuals, homelessness tends to be a longer-term event, primarily because assistance in housing search and provision of housing resources are even less available than they are to parents with children. In any event, the time period of the count — a one-night snapshot, or an unduplicated count over the course of a year — affects the result.

Finally, the ability of the counters to make contact with homeless families and individuals ranges from difficult to impossible. Families illegally doubled up with other families do not willingly identify themselves. Homeless people in hospitals, jails, condemned buildings, and other institutions are unlikely to be recognized as homeless. For many homeless people, the goal is to not to be identified as such, for reasons of safety, security, dignity. While the unwillingness to be seen as homeless often coincides with official unwillingness to see homelessness, the end result is an unknowable number of homeless people.

Shelter Provision as a Benchmark

In Massachusetts, counts by localities and the commonwealth have been attempted through “streets count” surveys of providers. The city of Boston’s Emergency Shelter Commission, in particular, has been exceptionally straightforward in acknowledging the limits of such a count and cautious in applying the resulting numbers to formulate policy. Generally, Massachusetts officials, providers, and advocates have focused on other measures of need, progress, and accomplishment in assessing homeless policymaking: examples include the numbers of persons served by a particular program and number of requests for service. Such counts have served as measures in claiming progress — or lack of it — in ending homelessness.

The number of persons sheltered by the commonwealth has served as the fundamental measure for both the state’s and advocates’ evaluation of progress in combating and preventing homelessness. Indeed, when he was elected, Governor William Weld indicated that he would use this measure as an indicator of the success or failure of his cuts in human service programs: “If the homeless shelters are absolutely overflowing come October 1, that will tell us something”⁵ While there is argument between advocates and officials about shelters as the ultimate measure of the success or failure of governmental policies (and the appropriateness of gauging whether a bad policy decision has been made in visiting the ultimate kind of devastation, homelessness, upon affected persons!), emergency shelter use can be a fair indicator, as

long as those in need have ready access to such resources. It certainly tells us something if the number of homeless sheltered by the state goes up or down — and state officials have grown increasingly invested in having the numbers decline — in telling us that homelessness is disappearing.

Massachusetts's stake in providing emergency shelter to homeless people began with Governor Michael Dukakis's 1983 inaugural speech.

Thousands of homeless wander our streets without permanent *shelter*. *And we must provide it* . . . Tomorrow morning in my office I will convene an emergency meeting of the new cabinet, the Senate president, and speaker of the House, non-profit organizations, civic and religious leaders, and representatives of the Coalition for the Homeless. We will begin immediately to put together a statewide effort which will provide the necessities of life to those in desperate need. We will establish a toll-free hot line for instant referral, twenty-four hours a day, seven days a week. If needed, we will draw on surplus state hospitals, unused public schools, and as a last resort, National Guard armories to *shelter* the homeless and to distribute surplus food.⁶ [Italics added]

Homeless families quickly became the focal point of the state's efforts in providing shelter, and it was not until years later that Executive Office of Human Services Secretary Philip Johnston made the verbal commitment to provide emergency shelter to every homeless individual in need.⁷ Chapter 450 of the Massachusetts General Laws, enacted by the legislature in the autumn of 1983, mandated that the commonwealth provide "a program of emergency assistance to needy families with children and pregnant women with no other children — [including] temporary shelter as necessary to alleviate homelessness when such family has no feasible alternative housing available, up to the maximum period subject to federal reimbursement." This program, emergency assistance, has come to be known as EA.

With few family shelters, Massachusetts began to use state-paid hotels and motels to absorb the overflow of homeless families who lacked emergency shelter. The hotel census quickly became a volatile policy issue, with media, legislators, and advocates pointing to the specter of (primarily) women with children subsisting in dilapidated, expensive motels.

The motel rooms are crowded. One room serves as a living room, kitchen and bedroom . . . Sickness spreads easily among children in cramped quarters . . . Cooking over a hot plate means quick meals with little nutritional value. Playgrounds are parking lots . . . Children's education suffer as the family moves from motel to motel. For parents, motel life is extremely stressful.⁸

As horrifying as the physical circumstances of homeless families in emergency shelters, however, state officials reacted even more strongly to the enormous cost of sheltering them. In the same *Globe* article, motel manager George Anderson, who received \$51,000 per month from the Department of Public Welfare to shelter homeless families, noted: "[The motel will be in the business of housing families on welfare for a long time to come because] eight mothers and their kids left last month for places of their own, but about eight new ones came right back in."

Where did the never-ending sources of homeless families come from? As the Department of Public Welfare (DPW) indicated to the legislature in its annual report, families receiving AFDC [Aid to Families with Dependent Children] benefits

live on incomes far below the level needed to meet basic costs of living. In its fiscal 1990 report to the legislature, DPW said:

The problem of families at risk of becoming homeless is increasing, driven in large part by a lack of affordable low income housing. A principal factor in this shortage is the reduction of federal support for new low income housing. For example, in FFY [federal fiscal year] 79 the federal government added 15,000 subsidized units to the Commonwealth's low income housing stock; by FFY87, however new federal production has decreased to less than 2,000 units.⁹

DPW further acknowledges that "AFDC benefit levels contribute to the problem." Indeed, with AFDC incomes far below the poverty line and only one third of AFDC recipients living in public or subsidized housing, the combination of high housing costs and low public assistance grants ensures that more than 60,000 families will live continually at the edge — or over the edge — of homelessness.

For most welfare recipients, shelter costs represent the single largest category of expenditure. In "Special Report: A Profile on Family Homelessness" by Dale Mitchell and Ronna Bernstein of Meredith and Associates, the authors noted: "Virtually every component of each [interviewed] family's shelter costs (rent, fuel and utilities) was beyond their meager financial capabilities . . . Given the mismatch between income and basic shelter costs, it should not be surprising to find that debt to shelter vendors (landlords, utility companies and fuel deliverers) was routine fact of life for those families."¹⁰ Given these 1983 findings, the situation only worsened in the following years. Between 1982 and 1990, housing costs increased dramatically, while welfare benefits lingered at levels of 30 to 40 percent below the federally established poverty line. While AFDC 1970 benefits were at the poverty line (not a very generous standard, in any event), benefit levels eroded greatly due to inflation. Between 1970 and 1987, welfare benefits rose 65 percent, while the cost of living, as measured by the Consumer Price Index, rose by 190 percent.

Table 1

AFDC Monthly Grants versus Monthly Two-bedroom Apartment Rents

Year	AFDC Grant for Family of Three	Two-bedroom Apartment Rent
1982	\$356	\$455
1984	\$375	\$528
1986	\$427	\$711
1988	\$510	\$830
1990	\$579	\$857

Source: Department of Public Welfare, City of Boston.

Efforts to address the enormous gap between housing costs and poor families' incomes throughout the 1980s were scattershot at best. As the Massachusetts economy boomed, housing prices were bid up by an oversupply of consumers and under-supply of housing units. Meanwhile, most of the state's housing policies were directed at moderate-income would-be homeowners, individuals with substantial special needs (mental illness or mental retardation), and rental housing developers. AFDC households received no special priority in obtaining what housing assistance was offered by state or federal programs. Cost-of-living increases were provided, but

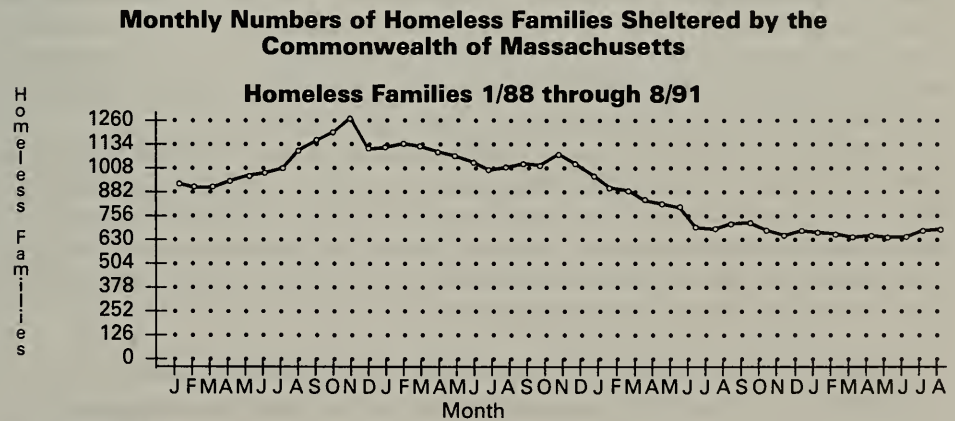
not nearly of the magnitude required to enable AFDC households to cope with private housing market costs. With one exception, described below, the state's efforts at assisting AFDC families in retaining their housing focused on services — landlord-tenant mediation, for example — rather than redressing the rent-income gap. By failing to address the real cause of families' homelessness, as acknowledged in their own reports to the legislature, the commonwealth ensured that its ability to substantially reduce or end homelessness was blunted. With a goal of reducing the number of families sheltered by the commonwealth and a lack of interest and will in pursuing the economically based efforts (with their attendant financial and political costs) to do so, the state became increasingly dependent on blocking access to shelter as a way to show success.

In one instance, however, the commonwealth created and implemented a program that exactly targeted the gap between homeless families' incomes and the cost of private market housing. The Chapter 707 Rental Subsidy Program, based on the federal Section 8 program, was used to great effect for several years to assist homeless families in escaping shelter. While the Chapter 707-assisted family paid a monthly rent equal to 25 percent of income, the commonwealth made up the difference between that amount and the capped amount charged by the private market landlord. With the assistance of state-paid housing search workers, the commonwealth soon found that with their rent-income gap addressed, homeless families were able to leave emergency shelters for permanent, affordable housing quickly. The budget cuts wrought by the last several years of the commonwealth's revenue problems, however, have taken their toll on the Chapter 707 program: in fiscal 1990, the state funded subsidies for two thousand homeless families; the following year, the number was cut by 60 percent; for the next two fiscal years, *no* subsidies were funded.

Making the Homeless Disappear

Despite the fact that AFDC families' incomes continued at levels too low to make housing affordable, the census count of homeless families sheltered by the state took a dramatic nosedive in the late 1980s, a nosedive unrelated to federal funding of

Figure 1



*Monthly totals

Source: Created by Leslie Lawrence, Massachusetts Coalition for the Homeless, from data supplied by the Department of Public Welfare.

housing, grant levels, rents, or housing vacancy rates. Rather, the number of homeless families sheltered by the state decreased as a result of the commonwealth's manipulation of eligibility criteria.

Officials' interest in changing eligibility for shelter developed soon after their idea of sheltering homeless families. An internal DPW memo to then Commissioner Charles Atkins advised:

One of the most direct methods for the Department to decrease EA expenditures is to limit the amount of benefits available . . . The Department could place more stringent constraints on the circumstances which create eligibility for the EA program . . . The Department could move towards a tighter definition of homelessness, thus limiting the number of families eligible for homeless benefits.¹¹

Atkins followed up on his staff's advice with a memo to his boss:

Emergency Assistance expenditures have grown recently at an alarming rate, tripling in three years from \$7.5 million in FY83 to \$23.1 million . . . It is essential to manage eligibility for hotel benefits to curb the rapid growth in hotel/motel expenditures. The Department proposes to implement an eligibility policy in which only families with a demonstrable need for temporary shelter could receive hotel/motel benefits.¹²

The department entered into a series of discussions with advocates for the homeless, in which DPW proposals to limit access were beaten back. Indeed, advocates succeeded to the extent that the department, in October 1985, promulgated State Letter 745. It specified that households eligible for shelter were those which were "rendered homeless for any reason except for the sole purpose of making itself eligible for EA." In light of later methods of narrowing eligibility, this DPW policy decision is remarkably open.

The hotel count continued to rise throughout 1985 and 1986, fueled by the increasing costs of Massachusetts housing. As it appears that homeless families in hotels were particularly bad for public relations, as opposed to homeless families in shelters, state officials made enormous efforts to reduce reliance on state-paid motels by developing a large network of private, nonprofit family shelters. Somehow, families in shelters seemed to signify homelessness less than families placed in motels. The number of shelters boomed, growing from two state-subsidized programs at the start of the 1980s to more than one hundred — excluding those for battered women — by the decade's close. Administration publications detailed the state's accomplishments in combating homelessness through its great expansion of shelter programs.

The shelter count reached its peak in 1988, with more than 500 families in family shelters and more than 700 in state-financed motels. Late in 1987, DPW announced a set of regulations that instituted a much more rigid system of admission to shelter and contained provisions allowing the department to toss families *out* of shelters.

Significantly, the EA rules, which were circulated in late 1987 and became final in the winter of 1988, allowed the department to

- devise a set list of reasons for homelessness. It included natural disaster, eviction, abuse, overcrowding, and government action, namely, condemnation of buildings.

- place families in a shelter within twenty miles of their community, or a contiguous community, of origin. This meant that homeless families from Boston were placed in shelters in communities like Lowell, Fall River, Taunton, Attleboro, New Bedford, Malden, Peabody, and Saugus, which some not only had never heard of, but could not find their way to them via public or private transportation.
- investigate whether a family had feasible, alternative accommodations with a friend or relative. DPW caseworkers often telephoned lists of persons provided by the homeless families. One mother contacted MCH, complaining that she and her children had been placed with a high school friend with whom she had not been in touch for a decade!
- require a client to sign a “contract” prior to provision of shelter. This quasi-legalistic document, detailing a prospective shelter guest’s responsibilities and agreement to abide by vaguely stated shelter rules, included a blanket authorization waiving the family’s right to privacy. This waiver authorized the welfare department to share information about the homeless family with any other agency of state government.

The effect of these conditions varied from local office to local office. While one had to be homeless for the right reasons to get shelter, documentation requirements were interpreted differently by different DPW workers. A caseworker uninterested in or opposed to providing shelter could use various departmental rules to effectively bar families from it. In a number of instances reported to MCH staffer Leslie Lawrence, DPW workers informed clients that their names would be put on a waiting list for shelter — a virtual stalling tactic, since shelter would never materialize.

As the regulations were implemented, problems in gaining entry to temporary shelter began to crop up. Correspondence to the department regarding shelter access included a variety of case examples, including clients who were told that “there’s no such thing as shelter any longer”; clients who were instructed to go to shelters twenty miles away, without transportation, or in one instance, directions being provided; clients who were forced to wait upward of four hours before being given an application for shelter; and women with children being placed in “line-up” barracks shelters for single adults.

Ms. P. and her two-day-old newborn child requested emergency shelter as her landlord has a valid execution from the court, and is ready to evict her. The worker told her that before she could be placed, the Department would need written statements from her relatives explaining why she could not stay with them, as well as written proof that she had applied for accommodations at the local shelter.

Ms. C. [then asked her DPW worker], “What are you supposed to do for a roof over your head?” The worker responded, “You can spend the weekend at Long Island [a barracks-style shelter for homeless adults] and get back in touch on Monday.” Hearing this, Ms. C. left. Ms. C. could not bring herself to take her three babies to Long Island.¹³

Homeless families already in crisis not infrequently — and not unsurprisingly — gave up in the face of these obstacles. Advocates had the experience of working with

families who had made repeated tries for shelter, and succeeded only when courage and desperation peaked.

As Figure 1 shows, the number of sheltered families reached its peak in late 1988 after months of increases, with more than 1,250 families sheltered by the commonwealth each night, the majority in state-paid hotels/motels. A typical seasonal decline occurred in December, as families stayed out of — or left — shelters during the holidays.

The Beginning of the End of Access to Shelter

In the spring of 1989, state officials began a new regulatory drafting process, which ended in the fall of that year. These regulations, still in place, marked the new era of highly restricted access to shelter. Advocates began to hear complaints of families unable to penetrate the emergency shelter gate and of families once again sleeping in cars, hallways, and hospital emergency rooms — situations that had all but disappeared during most of the 1980s. Shelters saw a rapid decline in the number of referrals made to them by local welfare offices.¹⁴ The hotels and motels began to empty out. Families who did manage to squeeze into shelters told of spending an average eight months in them.

The most dramatic changes were related to documenting the need for shelter, particularly for families who had stayed temporarily with friends or families. Rather than a self-declaration as to the need and reason for shelter, DPW required documentation to an unprecedented degree. Families were forced to prove that not only were they homeless for the right reasons, but that they had no feasible, alternative housing. For example, the commonwealth decided that any apartment costing more than 100 percent of a household's Aid to Families with Dependent Children grant, as well as substantial health code violations, was in fact a feasible, alternative housing option. Only when a household was ordered closed by the local board of health — the municipal agency charged with enforcing the health code — or a court would DPW agree to shelter the family.

Most controversial was the new rule that a family forced to leave a doubled-up situation needed verification from the Department of Social Services (DSS) that it was in fact necessary to leave. Over the past decade, MCH and its members repeatedly found that homeless families stayed temporarily with friends or relatives for varying lengths of time prior to a stay in a state-financed hotel or shelter. The term "doubling up" applies to a second, homeless, family moving into the home of a primary, or "host," tenant. Doubling up was considered a feasible, alternative accommodation by DPW. Such circumstances become untenable for a wide range of reasons, including severe overcrowding; threats by the primary tenant's landlord to evict *both* families from the apartment if the doubled-up family failed to vacate; medical problems created for either the primary tenant or the homeless family as a result of the overcrowding; mistreatment, sometimes to the point of physical violence, by the primary tenant; and the more mundane stresses and strains of two households — with differing styles of parenting, housekeeping, cooking, and maintaining household finances — attempting to coexist in living space meant only for one.

Doubling up as a means to forestall placement in state-supported shelters and hotels has been so commonplace, in fact, that an informal survey of residents of a Boston family shelter found that the average time spent living in other people's housing was over one year prior to entrance into a shelter.

The Department of Social Services developed an evaluation of doubled-up families which included a written assessment that there existed an imminent threat to the health and safety of the homeless children. If the DSS finds that there is no such threat, the homeless family is not deemed eligible for emergency shelter. The DSS assessment includes an evaluation of medical problems, protective risks, behavioral/emotional/development issues, "ability to perform parental duties," physical space, and school performance.

The new DSS assessment proved to be an effective tool in reducing the number of homeless families deemed eligible for shelter.

Since November 1, 1989, when the new Emergency Assistance policy was implemented, we [the Department of Public Welfare] have experienced an 18% reduction in the number of homeless families *needing* shelter. The caseload has been reduced from 1,067 to 872. The greatest reduction has been in the number of families who have to be temporarily sheltered in hotels/motels. The Department only uses these facilities when shelter space is not available.¹⁵ [Italics added]

Of course, it was not that fewer families needed shelter, but rather that the department provided shelter to a reduced number of households, using a very effective screening tool: an assessment by the state's child protection agency. An internal draft memo from the DPW noted that "DSS Assessments have resulted in almost 250 families remaining in their current housing situation since November 1, and not entering the emergency sheltering system . . . General consensus is that the DSS component is of great value to the new FY90 delivery system."¹⁶

Why should an assessment by the Department of Social Services be such an obstacle for families seeking shelter? Advocates found that a number of factors played a part.

- The DSS assessment process requires that a state worker visit the home of the friend or relative, where the homeless family is living. Thus, the host family, who is charitably providing a shelter, is subjected to the scrutiny of a state agency. This occurs despite the fact that the host family is not seeking any assistance from the Commonwealth. Not surprisingly, host families have objected to such an examination.
- In devising its assessment process, DPW chose a branch of state government, DSS, that frequently frightens homeless families, for fear that an attempt would be made by DSS to remove the children from the parents and place them in foster care. Indeed, assessments have triggered this process, both for host and guest families. What began for some families as a request for shelter ended in a custody battle with the state.
- For some households in crisis and already disorganized, the additional step of seeking and participating in a DSS assessment proves to be a step too much.
- For some DPW workers, the additional layer of bureaucracy required by an assessment provides a disincentive to understaffed welfare offices in offering shelter. A DPW worker told an MCH member that she didn't want to make a referral for a DSS assessment, because if it indicated an imminent threat to

health or safety, she would be forced to place the family in shelter. The DPW worker avoided the dilemma by refusing to make the referral.

- The standards by which DSS performs its assessments are inherently flawed. MCH staff have seen instances in which DSS decided that there was no threat to a homeless family's health or safety despite other evidence to the contrary, such as a doctor's certificate that the mother's health and that of her unborn baby were in jeopardy because of the sleeping arrangements of a doubled-up situation. Moreover, DSS has taken the position that a decision by a host family to kick out a homeless family *does not* constitute a threat to health or safety. Thus, MCH staff have examined DSS assessments which note that a homeless family must vacate its current refuge in two days, yet concurrently conclude that no threat to health or safety exists.

Overall, the routine, but informal, denials of shelter experienced for years by homeless families and their advocates became in 1989 an organizing system of rejection that left many families stranded.

The mission of providing emergency services to homeless families succeeded for most of the 1980s as Massachusetts created a sheltering system that provided temporary respite for essentially all homeless parents with children in need. At the close of the decade — 1989, 1990, 1991 — this changed. Despite a state statute that mandated the commonwealth's responsibility to shelter homeless families, an increasingly complex and burdensome regulatory system to manage the rising numbers of homeless emerged in the late 1980s. The state's efforts to provide temporary, rather than permanent, solutions to homelessness doomed their efforts from the start and ensured that the only means by which progress — as measured by the number of families in state-supported shelters and hotels — would be made would be through limiting the inflow of homeless families into shelter. The recent round of budget cuts, decimating the only state program which addressed the rent-income gap for homeless and poor families, portends a state response to homelessness that falls even further from a real solution than those pursued during the last decade. This lack of willingness to grapple with the economic causes and solutions of homelessness will only lead the commonwealth into even more draconian methods of governing who is in need.

Of all the ways to "end" homelessness, redefining a homeless family as *not* homeless must certainly qualify as one of the most inventive. It is also a strategy that favors short-term savings over longer-term ones, both in terms of government spending and the toll on the household. The problem of homelessness has become an intractable one only in that the solutions sought are limited in perspective. The economics of homelessness are simple enough — incomes that fall far behind the cost of housing — to make our collective lack of action inexcusable. It's time to focus on assistance for homeless families rather than wishing — or defining — them away. ♪

Notes

1. Eleanor Chelimsky, "Politics, Policymaking, Data and the Homeless," Fannie Mae Annual Housing Conference 1991, 4. Ms. Chelimsky is the director of the U.S. General Accounting Office's Program Evaluation and Methodology Division.

2. MCH is a statewide, private, nonprofit organization established in 1981. It is a direct service provider to homeless and formerly homeless people, as well as the leading advocate on public policy issues affecting homeless and nearly homeless people. For the past decade, MCH has primarily focused on affordable housing, income maintenance programs, and services to the homeless (both emergency and permanent). MCH accomplishes its work through advocacy, public education, organizing, and policy campaign work.
3. Letter from Thomas Connelly, Jr., executive secretary, Massachusetts NAHRO, to Joseph Flatley, assistant secretary, Executive Office of Communities and Development, August 28, 1985.
4. Notes from Ms. Kondratas's presentation to the board of directors, National Coalition for the Homeless, March 16, 1991. Ms. Kondratas is the assistant secretary for community planning and development at HUD.
5. *Boston Globe*, "Weld: Many Back Cuts," July 23, 1991, 17. Governor Weld's cuts for fiscal 1992 include the elimination of income assistance to families and individuals receiving General Relief; ending of housing development and subsidization funding; and the elimination of homelessness prevention programs and services.
6. Michael Dukakis, inaugural address, January 6, 1983.
7. While Massachusetts has a statutory obligation to shelter homeless families and pregnant women, it has never adopted such a mandate for homeless individuals. This is demonstrated in the use of hotel and motels for families; when the state runs out of shelter space, it uses hotel rooms. For individuals, when there is no shelter space, that's it. Homeless families are "allowed" to remain in shelters during the day and do not have to line up for a different bed every night. Homeless individuals must leave emergency shelters early each morning and search out a new bed each evening. Shelters such as the Pine Street Inn, New England's largest, have responded to this situation first by having individuals sleep on their lobby floor, and second by giving priority to the creation of additional shelter beds, at least during the winter months. This failure to provide even adequate numbers of shelter beds is an indication of our community's tendency to blame the single homeless for their homelessness. The sight of a homeless mother with children forced to spend their days or nights huddled in a doorway stirs our social conscience in a way no longer accomplished by a homeless individual.
8. "67 Cape Families Living in Motels," *Boston Globe*, February 10, 1985, 73.
9. FY90 Report to the Great and General Court of the Commonwealth of Massachusetts on Standard Budgets of Assistance for the Aid to Families with Dependent Children Program, January 1990, Department of Public Welfare, ii. As of August 22, 1991, the Weld administration had not complied with their statutory duty to submit an updated report.
10. "Special Report: A Profile on Family Homelessness." Poor People's Budget FY84, Dale Mitchell and Ronna Bernstein, May 1983.
11. Memorandum to Charles Atkins, commissioner, DPW, from Genia Long and Matt Fishman, Budget Office, May 13, 1985.
12. Memorandum from Charles M. Atkins, commissioner, DPW, to Philip W. Johnston, secretary, Executive Office of Human Services, July 30, 1985.
13. Letter to DPW commissioner Charles Atkins from Sandra David, Massachusetts Law Reform Institute, March 13, 1987.
14. Family shelters in Massachusetts receive, with very few exceptions, a substantial (75% and more) portion of their operating budgets from the Department of Public Welfare. In return, DPW reserves that percentage of a facility's shelter beds. Without referrals of homeless families from the department, shelters are at risk of going into deficit. This financing arrangement has given nonprofit shelters a fiscal interest, as well as one of social justice, in ensuring that homeless families have access to emergency shelter.
15. Affidavit of Robert D. Wakefield, Jr., *MCH et al. vs. Philip W. Johnston et al.*, February 23, 1990.
16. Memorandum to Nancy K. Kaufman, deputy commissioner for Program Operations, DPW, from Robert D. Wakefield, Jr., assistant commissioner for Housing, April 20, 1990.

Anger

A.E.S.

It starts as a tiny twinge of pain.
One is on the defensive.
The volume rises;
The words abuse.
It turns with great intensity
 into cursing and snowballs;
 it tears apart both the tyrant
 and the victim.
It does nothing but hurt,
 isolating each party from caring.
They cannot feel at one with themselves.
All serenity is destroyed.

Sometimes it goes farther
 than verbal abuse.
A fist is flung.
A feeling of fear
 permeates the atmosphere.
Oh God — what are the consequences?

A feeling of guilt:
I could have maimed
 or killed someone.
I am out of control.
After all these years
 I should have learned.
Why did I expose myself to this person
 who always hurts me?
Why do I abuse myself and others?

Innocent bystanders have seen
 my uncontrollable rage.
I can't forgive myself.
It hurts — that I make myself feel
 vicious, a villain
 one to be despised.

Tents along the Merrimack

Homelessness and University- Community Cooperation

Mark D. Levine, Ph.D.

This article presents historical, institutional, and ethical contexts for a university and an industrial, ethnic community's cooperative effort to address local hunger and homelessness. A large portion of the University of Massachusetts at Lowell's students are of working-class and local origin. Neighborhood social problems are in effect their own, and community service may be considered a variant of self-help. Attention is paid the special importance of developing a sense of community across traditional boundaries on and off campus and to the establishment of permanent mutually beneficial structures.

The University of Massachusetts at Lowell is in its third year of institutional involvement with Greater Lowell officials, service providers, clients, and community, addressing local homelessness and hunger. As this institutional energy is advanced, the university is participating in the nationwide expansion of the higher education campus community service role, under way since the mid-1980s. With the economy worsening and the potential reshaping of societal priorities, involvement seems to be especially important to both institution and community.

To explore this relationship historically and sociologically, searching for origins and models, for themes and implications of past and present experiences, I ask: In an era of social and economic distress, what can a university do to promote lasting and mutually beneficial ameliorative structures in the neighboring community and on campus? I zero in on the role of community service in helping the campus to strengthen its own community. Implicitly, I inquire into the origins and the appropriateness of our sense of being an elite and discuss the particular opportunities for local students in promoting self help strategies and the possibility of service learnings.

Lowell and Homelessness

Some thirty-five miles to the north of Boston, Lowell, Massachusetts (1990 population, 105,000) is undergoing one of its cyclical economic downturns, always a little worse than the state's, and the warm weather of early spring brings forth a sprinkling of inhabitants sleeping by its two rivers and its latticework of canals.

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The nation's first industrial city, Lowell has always been a magnet for waves of work-seeking impoverished immigrants. Not unexpectedly, it has experienced the full complement of urban problems, including a shortage of shelters for the displaced. The city's first immigrants, Irish who were collected from Boston and elsewhere in the early 1820s to build its canals, were accorded a tract of swampy, mosquito-infested land near the mills, the so-called Holy Acre. There they established a ramshackle tent city, the Paddy Camps. Over the ensuing 170 years, each most recently impoverished immigrant began his life as an industrial worker in Lowell in the ten-acre triangle known as the Acre, the current home of a crowded community of Southeast Asians and Latinos.

Even the utopian boardinghouse system for the "mill girls," the regimented centerpiece of an attempt by the mill owners to avoid the social problems of British industrial cities, deteriorated within twenty-five years. The legacy for American industrialism, highly influenced by this experiment, was benevolent paternalism, including the containment and disabling of unions. The forms remained, but the literal structures disintegrated.

With each wave of impoverished immigrants and workers displaced in the volatile modern industrial economy, the city was once again faced with a housing shortage, with homelessness and hunger. By the mid 1980s, in the throes of the recession, shelters and feeding facilities were founded to respond to the growing problem. By 1991, approximately 20,000 Lowellians were living at or below the poverty line. Five shelters, housing 1,260, and two food pantries, serving close to 2,000 families per month with four days' food, had been established. Members of families, especially women-headed single-parent households, outnumbered individuals among the city's homeless shelter residents.

By the summer of 1991, 250 teens were estimated to be sleeping out of doors, especially in the Centralville section of the city, across the Merrimack River from the largest of the shells of the great mills, now part of the large Lowell Historic National Park. University graduate student surveyors had learned of serious dislocations from the Cambodian community of 25,000, most later reabsorbed by the cultural and family network. A large food warehouse and a weekend soup kitchen had been established; a teen shelter and a municipal Hunger Homelessness Commission were on the drawing boards. The demographics of the shelter population began changing. A few suburban families began appearing, ravaged and disjointed by the economy; as they were being helped, several became eager advocates for reform, offering the first presentations by victims heard clearly in the city. By the fall, 20 percent of those at the "wet" shelter for single persons had come after they had exhausted unemployment benefits. A recent phenomenon was the emergence after a night in a communal sleeping room of a well-groomed executive whose house had been repossessed and family had split up. Carrying leather attaché case, he left for work, the experience of the shelter fresh in his mind.

Just before the municipal election, a few local businessmen convinced some of the city councilors to pressure that shelter to leave the city. A picket line at City Hall quickly formed. Members of the University of Massachusetts at Lowell service community joined the picket line in step with shelter residents, staff, and board. Area religious and personnel from other shelters provided an impressive show of support. The hearing on the shelter removal was postponed and a citizen committee later was formed. The battle lines of the American nineties were being drawn, and the university was taking its place.

UMass at Lowell: Class and Community

Picketing was not within the everyday persona of the historical institution, whose larger, more dominant subdivision, known to old-timers as Lowell Textile, had long represented to the community the power of industrial capitalism.¹ The more genteel part, the state teachers college, had represented what is known today as literacy and was local, or at least regional.

Born of these two contrasting institutions, each established in the late nineteenth century, the present University of Massachusetts at Lowell still has a clouded local identity. The larger institution, Lowell Textile (1895; later Lowell Technical Institute, 1953), organized by the mill ownership to provide the mills with ongoing improvements in science, technology, and management, was one of the best in the country in textile engineering and management; the second institution, Lowell Normal School (later Lowell State Teachers College) had been an excellent state training institute for teachers and the earliest institution of higher education in the nation to train music teachers.

The division between town and the two gowns is ancient and distinctly ideological. Historically, Lowell Textile (Tech) was attended by a population from far outside the region (whom Lowellians still call blow-ins). When locals remember Tech of the 1920s and 1930s, they picture turbaned East Indians on the streets of downtown Lowell. There were children of Yankee mill managers, bright ethnics, excluded by discrimination from the Ivy League schools, and Jews from textile business-owning families in New York city. To the locals, Tech was academically formidable, exotic, patrician, unconcerned, and distant, almost invisible. Beginning after World War I, the mills began departing for the southern United States and eventually, as technology and manpower adapted to synthetics, the institution retooled and diversified as a modern technical institute and university. In the 1970s, the Textile Engineering Department was gradually phased out. Departments like Plastics developed an international reputation.

In contrast to Tech, Lowell Normal, later Lowell State Teachers College, had a local identity. State admitted many graduates from Lowell High School and Tyngsboro's Notre Dame and placed many as local schoolteachers. The institution was regarded as competent, friendly, and regional and as providing a guaranteed job for one's ambitious daughter. The merger into the University of Lowell in 1976 blurred the identities of each of the institutions, to be confused again for some alumni and locals by the recent merger of the combined institution with the three other state university campuses and the medical school in Worcester.

What has changed more strikingly in recent years are the student demographics. The majority of current students are typically the first in the family to attend college and often local. The institution's constituency has come almost full cycle: from manager and elite to proletarian. Unlike their predecessors, the present students bring along, and continue to live vividly, the legacy of the economic roller coaster, currently in a tumultuous dip phase. At this writing, a dramatic increase in tuition and fees, a decrease in scholarship aid, and cuts of university service threaten to wrench from the students' tenuous grasp the long-sought key to social advancement. Many who last year lived in residence halls and local apartments have moved back home; some have dropped out, awaiting better times.

An unarticulated community of thousands of university alumni, retirees, staff, and student family live throughout the Western Merrimack Valley within twenty miles of the institution. Hardly a local family who has lived a generation here does not have a member or close friend with a past or present university connection. In marked contrast to these numbers is the common condition of this population of emotional severance from the university. Alumni donations are at about one third of comparable institutions nationally. The university staff is of local origin and some of the faculty as well share the values and concerns of the region housing it. I will return to the larger university-community relationship, in which the local student plays a crucial role.

As the institution reaches out to the local community's needy by expanding its service component, it is resonating with dirges familiar to the students. Yet, an increase in campus volunteering has occurred quite spontaneously, in timely contrast to the stereotype of campus community service as existing exclusively between upper class private college student helping poorer local person. The stereotype has a long social history in both higher education and community service and is worth examining critically.

The American University and Community Service

Community service in American higher education has largely religious and classist origins, exemplified in the early twentieth century by the student YMCAs and the venerable community service programs at Stiles House at the University of California at Berkeley (UC/Berkeley), Dwight House at Yale University, and Phillips Brooks House at Harvard University. Although much lip service was given to democratic ideals, personal ennoblement was the goal of both service and higher education at the classic service institutions, Antioch, Oberlin, and Berea. In the mid-nineteenth century, public institution community service was given a large boost in the stipulations for federal establishment of land-grant colleges, many to become today's large state universities. In later years, this involvement of the publics waned, and only recently is it being reinvigorated, often in emulation of and led by the privates.

By the turn of the nineteenth century, the pronouncement of the social reform possibilities promised within the American experience entered the programmatic context of mainstream Protestant missionaryism. Enthusiastic college students from Harvard traced the progress of immigrants in Boston's industrial suburbs at the turn of the century and laid some of the groundwork for the professionalization of community service as social work. They and their Ivy League counterparts swung with a mighty stroke the double-edged sword of help and prejudice; the mix characterizes community service to this day as the richer and more educated continue to set the terms of social amelioration of the poor.

Significant evidence of the elitist feature is the availability of large amounts of funds. Thus, the Phillips Brooks House (PBH) Association at Harvard is housed in an endowed building, assisted by a paid staff, and availed of major funding opportunities for its plethora of projects. While the heart of the PBH program is the student committee that receives, trains, places, and provides support for university volunteers, there are also grants available for consultants, equipment, and so on. A variant is Stiles House at UC/Berkeley, where students earn salaries working on established projects and are supervised by paid staff. Established just off campus as a nonprofit, it receives the majority of its funding from the United Way. Its historic record of

independence includes dogged protection of free speech during the state government sieges of the early 1960s.

The 1960s: Experiential and Service Learning

Following the World War II and the further secularization of American life and its institutions, a gradual shift occurred in campus discourse regarding community service, from its role in the development of Christian character to its function as a source of understanding in the social sciences as generator of social change and shaper of values.

The role of public and community service in higher education was a topic of the university self-examination that blossomed in the late 1960s. Drawing on a tradition emphasizing the role of experience in education, especially John Dewey, there emerged a critique of contemporary education as separate from and irrelevant to the mass of the experience of the general population. The writings of A. S. Neill, Ivan Illich, Paul Goodman, and others helped educators nationwide consider alternative missions and curricula, some involving service to the community, especially in the form of social change. Melding experience and education, making education applicable, relevant, value reflective, and change oriented helped established a place in the academic curriculum for analysis of the root causes of social problems: poverty, violence, racial and gender discrimination. The traditional boundary between campus and community was permeated and personal and social change activities became fit for academia. This period witnessed the establishment of such new applied community service fields as community psychology, formed from a combination of community organizing, clinical psychology, and social work. Looking backward, we remember the era as one of unbridled optimism.

Institutional changes in the university format and client followed. Colleges such as Antioch, Goddard, and Northeastern had long offered as mainstream curriculum the value-reflective integration of work and the undergraduate course work. In the atmosphere of self-examination, accompanied by the imperative of change felt in the late nineteen sixties and early seventies, and spearheaded by both education progressives and conservatives, this effort was expanded to include public state university systems and national networks. These adult external degree programs emphasized service to so-called nontraditional students (older, working, housewives, poor, minority). The first were the statewide Empire State College (State University of New York) and the national University Without Walls (Union of Experimenting Colleges and Universities) network, which soon offered to scores of adults the opportunity to blend experience and education and thereby to legitimate learnings from paid and family work, and from community service. Generally seen as a blessing by students hitherto excluded from or bypassed by academic and credentialing enterprises, some of the early participants also expressed concern that community leadership might be co-opted and diverted by academic control and legitimation.

A related development was the gathering of a single social science college curriculum around service. Grounded in a carefully constructed blend of community organizing and self-help methodology with academic methodology, such programs again included in their student body adults, working class and minority. In New England, the most significant of these was the University of Massachusetts at Boston's College of Public and Community Service (CPCS). CPCS frames its undergraduate and

graduate curriculum of theory and practice around service areas, ranging from legal to housing to gerontological services. Included is the educating of lay and practitioner students to be effective advocates. There is hardly a metropolitan Boston community or state agency or service organization that has not experienced its salutary influence, from its well-trained graduates in the public and community sectors to its surveys of vulnerable populations leading to changes in local policy and legislation.

Campus Rebirth of Community Service

The national trend in campus community service has been logged roughly in fifteen-year intervals, rising during periods of social and economic strain and idealism: from the Great Depression to the end of World War II (1930–1945); during the Civil Rights/Vietnam War era (1960–1975); and gearing up again during the economic bubble burst of the 1980s. By the turn of the 1990s, research showed the student body beginning to shake off its earlier reported narcissism. A national study examining social awareness as the student proceeded from high school to college concluded that high school student involvement in social service is at one of its highest points in twenty years and seemed to be positively correlated with social service. For the first time in recent years, student chose altruistic goals over capitalistic goals.²

By the mid-1980s, deliberate campaigns had been initiated at student and president level, followed several years later by a push for federal programs. In 1984, a young Harvard University graduate walked a sixty-five eastern college campus circuit, Johnny Appleseed style, to share a Harvard presidential letter on community service. The result was the founding of the Campus Outreach Organizing League (COOL), which now advises more than 450 campuses on community service. While not represented on as many campuses in Massachusetts as elsewhere, it has impressed many as a genuinely student driven operation. In their organizing, they have asked: How do we experience the power of a large number of involved students? They pitch for an ongoing commitment rather than a sudden one-shot burst of volunteer energy.

In 1985, three university presidents sat down and commonly experienced the Campus Compact, an influential organization of some 250 presidents of colleges and universities, including many of the most prestigious nationally. The premise is that commitment to service enters from the top and then from the bottom, the students. The Compact's mission is the increasing and focusing of community service delivery by the members' students, the linkage of service to curriculum, and the publicizing of the service aspect of their institution. Recently, the Compact has been attempting to fight off its reputation as an organization of the elite and as secularizer of service.

The Compact leadership point to the tradition of more spiritually based community service, to some extent a continuation of the earlier Protestant tradition, at the eminently successful programs of Compact members Notre Dame and Georgetown Universities. Indeed, a Jesuit psychologist I spoke with in San Francisco commented that service may be perceived as an obligation of the Eucharist. A further rationale for such service is expressed by Sister Gabrielle Husson, retired president of the Newton College of the Sacred Heart, who recalls community service at former Newton College as

based upon the faith of the students, never for credit and quite extracurricular. First, service should be the outcome of one's education, of knowing more about the government and about people's needs. A really successful education should

bring the student to the outcome that the student owes something to society. Second, education enhances and reinforces the motivation for the service and focuses students on what they can do. Third, people who respond to the call to serve are those who have the long range view. College students delay gratification, give a year of their life, they put off going into business or their profession, they get away from just making money and having the easy life. Service and education come together around the issue of sacrifice. Service is today's challenge. If students do it only in college, it still is a great experience: at the very least, they will have had a warm feeling for doing something for others.³

Following a groundswell of community service in every cranny of the nation, especially in the schools and universities, the federal government is taking the lead. The president set the tone by promising to institute a "community of light" to recharge the country with volunteerism. At present, three related entities exist: the National Office of Community Service, which provides public relations and recognition; the Points of Light Foundation, which institutionalizes and promotes the concept; and as a final spinoff, the National Community Service Act of 1990, which provides the funding. Under the act, a national youth service corps and a myriad of school and university service linkages with community will be developed. In Massachusetts, one goal will be to encourage school reform, for example, search for ways in which service can become part of the grade school curriculum. It is this legislation, one of whose sponsors is Senator Edward Kennedy of Massachusetts, that encourages service learning and the development of lasting changes in the national health.

Community Service and Citizenship

It seems a common assumption that community service in college will lead to increased citizenship after graduation. A Campus Compact leader I spoke with seemed to imply that his linear definition of community service included "the exercise of civic responsibility by applying knowledge and skills to ameliorate a social situation."⁴ It is this reasoning that causes Robert Bellah et al.'s *Habits of the Heart* to be a well-worn tract of the community service field and the strengthening of community to be seen as its goal.⁵

Harry Boyte argues that young people's community service is commonly experienced as personally significant, but students as often indicate that they are expecting to abdicate from civic action in the future. Boyte, in comment on the National Community Service Act, notes that community service counters an inner sense of purposelessness in the young server on the "private" level, but fails to generalize to civic or political behavior in the "public" sphere. Boyte argues that today's youth feel not disillusionment but considerable anger toward the political process. This anger is not addressed by the performance of community service, which provides them rather with a needed opportunity to feel useful. In providing students solely opportunities to feed shelter residents, they are being abetted in their individual need, but kept from the public role. Boyte argues that only through the young person's experiences of empowerment can preparation for later roles of citizenship and political life occur. These experiences are not specified.⁶

A Model Regional Collaborative

Homelessness, housing, and hunger are among the major targets of today's student servers. By the academic year 1991-1992, out of 105 Campus Compact member

institutions responding to a survey, 74 had established housing/homelessness programs and 74 had hunger programs. Eight institutions or regional collaborative had specifically targeted homelessness.⁷ In the fall of 1991, I visited one of these, the (San Francisco) Bay Area Homelessness Program, and came away wondering if this model might be useful in the Northeast. Certainly the program generated hopefulness, one of a university's particular spiritual contributions. After two years of experience funding this publicized, powerful, and versatile regional collaborative of colleges and universities, the enthusiastic corporate founder had suggested that the university may be the institution capable of solving the problem of homelessness.

In 1987, the state of California somewhat backhandedly laid the groundwork for the effort by requiring by legislation (but without accompanying funding) that students at four-year public colleges perform an average of thirty hours of community service a year. The California Compact has helped eight (now ten) public, private, and parochial higher educational institutions in the Bay Area launch this foundation-funded collaborative effort targeting homelessness. The collaborative's coordinating offices are at San Francisco State University, where service-conscious students have long worked with the homeless, whom they pass in great numbers on their way to campus.

Among the collaborative's strengths are the recognition of individual institutional missions and characters, and thus the fostering of a full array of public, private, parochial, university, state, and junior college projects. Featured generally are tie-ins to curricular and preprofessional areas. For example, engineering students are making toys for the homeless, elementary education majors are tutoring shelter youngsters, and communications majors are creating brochures and writing publicity stories.

UC/Berkeley has developed a community-based homelessness prevention program featuring a suitcase clinic, the suitcases carrying the necessities for examinations of the homeless by undergraduate and graduate medical and health students. In the Roving Résumé Project developed at San Francisco State, trained students help shelter residents present their skills in résumé form in conjunction with job training. This is at once a supportive counseling process and an attempt to solve a problem underlying homelessness — joblessness. After taking a course on homelessness taught from a public policy perspective, a homeless person emerged from the student ranks to teach the course, which now includes experiential activities. Laudatory stories about these projects have appeared in national and foreign media.

The outside community, especially its homeless members, is actively involved in the program's planning and delivery. The collaboration was inaugurated with a series of three open town meetings on the subject of what a university can do to solve social problems. Agency staff, the homeless, and the formerly homeless are included on task forces. At San Jose State, an alliance with the homeless has been formed and expanded to include "all those without power." The Roving Résumé Project, inaugurated at a résumé writing day at a shelter, took off dramatically when residents were attracted to it. And, based upon the premise that homelessness is a social status, a plan is in the works to enroll the homeless in college, thus eliminating status barriers related to their condition. As students, they will have housing and medical services, for example.

Finally, institutions are free to reward the student's service in their own way, that is, with credit, recognition, and so forth, integrating it into an education at that institution in varying degrees. Thus far, the campuses have stressed innovations and expansion of service and understanding the problem of homelessness. For the next

two-year period, "advocacy" (the organizing of pressure so that people know they have a chance to win something) is to be emphasized.

Community Service: Tradition and Challenge

Thus, in contrast to the traditional elitist and religious traditions of university community service, a counterforce emphasizing understanding, social change, community participation, and citizenship has regularly burst through, especially in recent years. Clearly, the public institutions have an important role to play, especially those that are community institutions. On the other hand, sorting out their identities and roles is a particular challenge.

In two regards, the sources of community service at the University of Massachusetts at Lowell are the most traditional: (1) community service as an enhancement or obligation of cocurricular (out of class) life. Student residence halls, organizations, and clubs include service among their activities. (2) community service as an essential of religious life on campus. As on other campuses, campus ministry stresses community service. Paralleling the region's demographics, the majority of students on campus are at least nominally Catholic. The religious center serving Catholic students has developed as its major service target of the past few years a large religious shelter for homeless families. This parallels the city's definition of religious charities as the more worthy of support.

The third expresses the university's unique role as neighbor: (3) community service as an aspect of the city as laboratory. The university has been quite up front in proclaiming that the city is ideal as a laboratory for applying theory and practice. With university help, the city has been linear and rational in approaching its recovery from the last of its disastrous declines. Beginning in the mid-1970s, the city of Lowell engaged in far-ranging economic and cultural planning, ultimately in a heady, visionary effort reflecting university values called the Lowell Plan, generally unprecedented in the commonwealth. As the electronics industry provided a long-overdue burst of economic libido, Lowell's "Massachusetts miracle" became a hook upon which Governor Michael Dukakis hung his 1988 presidential campaign. What signaled the success were the several hundreds of thousand tourists from across the nation and world who annually visited the Lowell National Historic Park, the centerpiece of the downtown that occupies twelve acres of refurbished mill buildings and other facilities and is preparing a canal system to rival that of San Antonio. The results created both the intellectual climate and the physical structure for fieldwork for countless university curricula and undergraduate, graduate, and professional practice and internships.

(4) Community Outreach. Since the merger in 1976, under the leadership of President (now Chancellor) William T. Hogan, born and bred in the heart of the city, the university has built a set of bridges to the community in the form of technical industrial, educational, and artistic centers. In one of these centers, the service relationship has been explicitly thought through and the term *responsive collaboration* coined. The accompanying maxim is "never do what we haven't been asked to do," i.e., to respond consciously to both community and volunteer needs. This tone would provide immediate backdrop for the university to formally enter the field of community service.

Unfortunately, Lowell's ten years of successes were followed by dramatic economic falterings, forecasting the state's decline and functioning for the governor as

the "emperor's new clothes." The local former mill workers and their families, an aging population making up 25 percent of the city, were among the disillusioned. They noted the high price of downtown real estate and the disappearance of stores providing everyday necessities other than those providing the historic stage set for the city's preservation effort. While the preservers were memorializing yesterday's workingman and -woman, they seemed to be providing dubious benefits for today's; since preservation aided in the gutting of the downtown, it may well have contributed to today's homelessness and hunger in the city.

For the university, the laboratory has developed a crucial social dimension. The challenge today is to follow through with the city during truly hard times, to be more than a summer soldier. The elitism of the institution is at stake: no longer can it count on providing service to the community strictly on its own terms.

A Structural Addition

In the fall of 1989, the stage seemed set for a general foray of the university into community relations and service. Following a suggestion of then board chairman and former U.S. senator Paul Tsongas, President Hogan launched a small Office of Community Service (OCS). To facilitate flexibility, its agenda was left open. Thus was available the groundwork for a testing of the possibilities and limits of university service to the neighboring community and a consideration of the role of service in an education at a university so connected to its locality.

The University of Massachusetts at Lowell and Homelessness

During the spring of 1990, the president of Lowell's largest domicile for the homeless convinced the Catholic bishop and the Lowell assistant city manager to promote a Hunger Homeless Week the following November. The shelter, the subject of a picket line in November 1991, is located in a downtown human catch basin in the shadow of operating and dormant mill buildings. The structurally unemployed and underemployed are domiciled next door to prostitutes, drug addicts, and the mentally disturbed in compact, industrial dormitory rooms. Public schoolteachers who cannot pay their rent mix with elderly poor. The case was easily made when the city officials visited and saw childhood friends living at the shelter. The university was invited to the first planning session in June of 1991.

The bishop expressed a particular interest in increasing local awareness, and made a strong case for awareness as the first goal of the week, with networking second and fund-raising third. It seemed comfortable for the university to offer educational programming. The city's conception of the university contribution was collecting for the shelters and food pantries, serving meals at the shelter, running in a road race, and stretching "arms across the shelters." We made two additional offers: to prepare an informational folder and to organize teach-ins. The folder discussed the local and national problem, stressed housing shortage and poverty as causes, identified families as the most rapidly increasing population of homeless, listed the shelters and food pantries, and culminated in a "what you can do" section. Some fifteen thousand copies of the brochure were circulated on the campus and throughout the city network of shelters, agencies, churches and synagogues, some businesses, government facilities, schools, and libraries.

The three sessions of Gown and Town Teach-ins, two at the university and one downtown, were designed to proceed developmentally from experience to analysis to action. Session 1 offered a taste of the problem and community service from volunteering students, shelter personnel, and university ministry. Session 2 offered faculty, staff, and student research on the problem, including a presentation of the history of federal public housing.⁸ Session 3, held at an in-town setting across from City Hall, featured government policymakers discussing their recommendations. The preparation of these in collaboration with the community planning committee provided an opportunity to address public attitudes to the city's homeless and to social services. They represented an important statement on inclusiveness of the parties concerned with the problem and the first steps in building and strengthening a community of concern.

In Lowell, ethnic and religious roots run deep and political power is carefully segmented as well. Historically, neighborhoods and many services in the city, including some public services, are known in their French-Canadian, Irish, Greek, Polish, and other identities. Religion, often Catholicism, plays a large role in city events and services. The first challenge to the planners was to break down old barriers and prejudices.

The negotiating of inclusion began as a quiet subtext to planning the week's events. Gradually there occurred greater acceptance of the two affiliated family shelters funded largely by government funds, which also tended to serve more of the city's homeless Latinos, and even of the city's confidential homeless facility, the shelter for battered women and their families. The religious sister director of the family shelter, which had initially been proposed as the sole family shelter to receive funds from the event, played a central role in bringing in the other secular family shelters. The "dry" family shelters began to support the much more visible "wet" shelter. Discussion began of common collections of food, clothing, linen, and furniture by the shelters and pantries.

The significance of this development went even further than the breaking down of a social barrier and the decision to work cooperatively: a discussion had begun thereby of the future of the city, on some of its new parameters, and on the creation of permanent new structures, ultimately on campus as well as in the city. At the last of the teach-ins, with little fanfare, a proposed piece of legislation emerged. This followed sharing between Lowell officials and a director of a major Boston service agency leader and was translated in the days following into legislation for a Lowell municipal commission on hunger and homelessness. The three initial planners of the commission represented city management, city council, and university, soon supplanted by the Hunger-Homeless Task Force.

Commissions signal new formats and generate both heat and light. The first City Council discussion was noted in the front page headline of the May 22 *Lowell Sun*: "Homeless Issue Sparks Debate." The story noted that the city councillor who introduced the ordinance for the commission — who is also a part-time university professor — was labeled by a colleague a "flaming liberal" for "making Lowell a magnet for the hungry and homeless" and for bringing in "new problems."

During the eight months necessary for the home rule petition of the commission to receive the required state legislature and governor approval, some of the systems proposed in the ordinance have been developed by the Hunger-Homeless Task Force: for example, the beginnings of centralized collections for the shelters and food pantries; a refocusing of energies on housing; the further development of the community of concern, presumably to serve the commission. At the same time, the

economy had worsened and forces within the city had mobilized to attempt to drive the "wet" from downtown.

A second year of Hunger-Homeless Week had been organized. The successful structure of the first year's event and artifact were maintained: the religious worship service; the week's symbol, two circles, one containing in red and black a house, and the second, a plate with knife, fork, and spoon, each with a negative black diagonal line across it; the canisters for collecting money; the hand stretched between the shelters and food pantry and the walk to city hall; the fund-raising dinners; the road race; and the folder and teach-ins. Planning was simpler and approached with some exuberance. After the third teach-in, a further meeting was scheduled, in anticipation of the return of the commission to the city.

New combinations of persons occurred and new issues were addressed. The low-cost housing planners began to meet with the shelter and food pantry network to share concerns and strategies. Child hunger had become the cause of an active member. Support was developed to help overcome opposition to a teen shelter. On January 28, in testimony at the hearing on the state-approved commission, because of concern that city councillors might construe the commission as a vehicle for establishing new shelters, emphasis was placed on the pursuit of new housing. The council's affirmative vote was unanimous.

In a parallel development, the federal ACTION agency awarded the university's Office of Community Service a Volunteers in Service to America (VISTA) program. Six VISTAs were soon in university-community collaborative sites. Each assignment was to increase university participation with targeted populations in the Greater Lowell area, including one with the city's Homeless Shelter Network, shortly to aid in the development of the new commission. The principle of the VISTA involvement is to facilitate new services and structures, which will remain after the assignment. During the second year of the Office of Community Service VISTA program, two VISTAs will work on low-cost housing programs.

The University as Community

With the strong support of the university chancellor, the university's community service program and the Hunger-Homeless affiliation has been able to offer important side benefits for the university. Just as performing service improves the student self-concept, employees value themselves as returning some of what they have received, especially during a time of fiscal strain. Employees, retirees, alumni, and students are recognized in the annual Community Service Recognition Week organized by the Office of Community Service each spring. This in turn strengthens workplace morale and product. The 1992 theme of Service Recognition Week is Service Learning, to confront the educational component as well as the faculty.

The University as Neighbor

Lewis Mumford has written that

to share the same place is perhaps the most primitive of social bonds, and to be within view of one's neighbors is the simplest form of association . . . Neighbors are people united primarily not by common origins or common purposes but by

the proximity of their dwellings in space. This closeness makes them conscious of each other by sight, and known to each other by direct communication, by intermediate lines of association or by rumor. In times of emergency . . . neighbors may even become vividly conscious of each other and capable of greater cooperation.⁹

Local students and local employees present a particular opportunity to be neighborly, yet barriers of consciousness remain to be worked out.

A Working It Out Model¹⁰

Grounded in principles of community psychology, the model is an attempt to explain the dynamics underlying community organizing strategy. It posits different cultures (social groups), each with its own ideology and methodology in accomplishing its goals. Working it out is a process of discovery of goals held in common and the creation of a cooperative campaign around these. In the hunger-homelessness campaign under consideration, there are probably three cultures involved: university, student (and university staff), and community. What is especially interesting here is the role of student and University staff midway between community and university. Thus, a model of local student community service provides a point of departure.

Toward a Model of Public Service for the Local University Student

Let us first examine the assumption that middle and working-class university students are less appropriately volunteers than more affluent students. This is because, it is argued, they are too focused on their own economic problems and too busy working to make money to serve; because service is a *payback* by those who have received society's bounties and not to be expected from poorer folk; and because they do not live on campus, where student activities such as service are organized. All of these raise legitimate questions.

Class issues affect service. The tradition of serving, of paying back, is grounded in identity. Especially for the nonelite student, identity is often grounded in institutions other than the university. A Southern California-based Chicana leader I interviewed describes the phenomenon. While a student, she was hired to direct the campus office of community service. Despite the personal connection, her *compañeros* consciously shunned her office and performed service only through the campus Chicano organization. There, they felt comfortable that the programs would serve their *raza*, which appropriately deserved the payback from them. With its 4-H values, the official community service office simply felt too Anglo. While my informant was currently serving the mainstream community service establishment, she would soon be leaving to begin a career in teaching. On our campus, a major route to service is the Catholic Center, probably for similar reasons.

As the depth of the economic trough is felt in our institution, we are experiencing increased volunteering, literally an increase in student altruism under fire, and probably an increase in self-help behavior. Those with prior experience serving are in the majority. Our experience is consistent with the Community College Compact based in New Mexico, who find that their students make "great volunteers, especially if they've been involved before in their communities."

To hypothesize about some of the psychosocial dynamics of local students, the obscure but important work of the British social theorist Richard Hoggart provides a base. Hoggart analyzes, with a bit of British Left romanticization, the experience and dynamics of the upward mobility of the new working-class student in British adult

education settings. The experience is intended to be democratizing and liberating, but since cultures are clashing, turns out quite differently. The newcomer to the middle-upper-class world of education is characterized as "uprooted and anxious," teetering "at the friction point of two cultures." The new learner is inclined toward intellectual passivity and what Hoggart calls "moral paralysis." With street sense dulled, the new learner is "cautions and lacks resilience." What Hoggart considers his natural working-class openness has become distrust: he has difficulty "responding to the genuine in others." From the standpoint of community service, we watch his useful intuitions and compassion drift away. Yet Hoggart believes that the new learner holds on to just enough of those sensibilities. The out-of-place student can draw upon and apply critically the "still considerable resources of working class" people and continue "putting their own kind of vision in what may not really deserve it"; that is, into being compassionate in way transcending the linear world of school or education.¹¹

This reservation seems to describe the germ of university community service for all students and certainly for locals. Indeed, I believe that it provides an important rationale, confirmed in our experience, for the inclusion in the educational experience of public and community service. Helping one's literal neighbor becomes potentially much more than noblesse oblige, or a payback. So construed, community service can be witnessed as intrinsically empowering to both recipient and receiver. It frames usefully the argument that students should shape and direct their own service activity. It makes community service self-help. It provides a response to Boyte's concern: empowerment can quite naturally be an ingredient of community service. This experiential counterpoint to noblesse oblige is important to maintain. The converse of this approach seems well worth avoiding: that the student be impelled to help on terms other than his or her own, that is, to impose inappropriately the university or academy's values on the recipient of help.

A Pluralistic Approach to Community Service

Bringing together the two elements above, this would suggest the importance of blending approaches, acknowledging on the campus a range of motivation for community service: from religious impulse to ethnic identity and values to academic and profession outcomes; and second, a parallel mixing of cultures within our work in the community. Clearly, the traditional elitist approaches of the university community service field are to be questioned if institutions that overlap so clearly with their communities are to realize their full service potential.

Roles and Responsibilities of the University

1. *Friendly listener.* This is the most important, without which others diminish in effect.
2. *Friendly agitator (teacher).* The university can stir the intellectual pot.
3. *Advocate.* The university can support and raise issues and viewpoints that lie within its expertise, methodology, and values; for example, regarding the need for long-range, preventative planning and for empowering strategies.
4. *Arbiter.* By remaining beyond local politics and power struggles, the university can emphasize equity and arrange meetings and reconciliations, especially in commonly encountered areas where prejudices get in the way. The community can provide the opportunities by agreeing that the university in fact has this responsibility and, at the very least, possesses a fresh perspective.

5. *Provider of a source of hope.* By presenting the social issue as a problem in understanding for which there exist rational solutions and then attempting to apply them, the university can clarify its role to itself and the community. Implicit are *ethical* lessons for itself and others.

The simple sounding offer belies its complexity. Lacking the distance, local students are vulnerable to the fatalism regarding social problems and their own economic plight. Being dangerously close to the problem may cause them to draw back. The university's education may prove useful in supporting with sound theory the students' proclivity to help themselves and their neighbors. Service learning has a special purpose in this context.

6. Perhaps the most important challenge for the future is to make the distinction between university community service for character development and a feeling of usefulness and service for citizenship. I believe that they are not as separate as Boyte suggests, but the caution is extremely important. This is the university's great task: to give meaning and power to the impulses, if not the habits, of the heart.

7. Especially at the local institution, the university can demonstrate its intrinsic value to itself and to the community outside its walls. At a time of diminishing funds for public higher education, this offers the university survival benefits. At a time when career choices for its graduates are scarce and obfuscated by conflicting values, the implication that service is a worthwhile vocational pursuit and professional consideration has importance for both university and its communities. ♪

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Notes

1. The administration building is named after an early board chair who was also the mill owner's representative in the forced settlement in Lowell of the 1912 strike. A single community-helping moment from Textile's past was recently recalled: the opening of the classrooms of the Textile Institute to some of those displaced in the 1936 flood in the city. Then, with considerable magnanimity, the temporarily homeless were given shelter.
2. Interviews with Diane Lugo, assistant director, California Campus Compact, August 28, 1991, September 8, 1991.
3. Interviews with Sister Gabrielle Husson, August 29, 1991, October 12, 1991.
4. Interview with Roger Nozacki, project coordinator, Campus Compact, August 28, 1991.
5. R. N. Bellah, R. Madison, W. M. Sullivan, A. Swidler, and S. Tipton, *Habits of the Heart: Individualism and Commitment in American Life* (Berkeley: University of California Press, 1985).
6. Harry Boyte, "Community Service and Civic Education," *Phi Delta Kappan* 72 (June 1991): 765-67.
7. *Campus Compact: The Project for Public and Community Service*, September 1991, 39-44.

8. Ronald Dale Karr, "Shelter the American Way: Federal Urban Housing Policy, 1900–1980," forthcoming.
9. Lewis Mumford, *The Urban Prospect* (New York: Harcourt, Brace, Jovanovitch, 1969), 59.
10. Mark D. Levine, "Working it Out: A Community Re-creation Approach to Crime Prevention," *Journal of Community Psychology* 14 (October 1986): 378–90.
11. Richard Hoggart, *The Uses of Literacy* (London: Chatto and Windus, 1957), 286.

Streets Are for Nobody: Marybeth

Twenty-one; "black sheep"; beaten by mother, later by boyfriend. Arrested for dealing drugs; in alcohol treatment program.

I was doing a lot of drugs. I was screwed up and I started drinking, and when I did, I had a blackout. I never had a blackout before. The last thing I remembered was I was in the park with my friends and we had just gotten high and I had drank some Peach Schnapps and the next thing I remembered I was looking over a bridge down at some rocks. I have no idea how I got to the bridge, but I assumed I was going to kill myself. Solomon [Carter] Mental Health was around the corner. And I was so scared that I walked to Solomon's because I really thought I was going to kill myself and wouldn't of even known I was killing myself.

They told me that I wasn't crazy and I wasn't suicidal, but I had a bad problem with drugs and alcohol and that it was making me suicidal so that I needed some help.

My problems I thought started when I was drinkin' in the park, but they didn't. Started when I was real young and I didn't even realize it. My mother's alcoholic. My father's an alcoholic. I was, um, ah . . . an unwanted child. I was a mistake. My father hated to look at me 'cause every time he looked at me just reminded him of what my mother had done to him. My mother hated me because of every time my father would look at me, he'd hate her more. I always felt that growin' up. Then, when I found out that my father really wasn't my father, it all fit together for me. I understood everything then.

My sister and my brothers will be talkin' about, "Do you remember this, do you remember that?" and I honestly don't remember it. I seen a psychiatrist and he said that — I just blocked it out. But, um, when I was younger, I can remember times when my mother would just snap, and she'd grab me by the hair and she'd just start beatin' on me and beatin' on me and my older sister would just literally throw her body on top of me and let my mother beat on her because — I just couldn't take no more.

And, um, another time was in the tub. I didn't want to wash my hair — I used to hate to have my hair washed — and they got me the goggles that you wear in the water and all kinds of things, but I didn't want to, and my mother snapped and tried to drown me. I was blue. If my father didn't come in, I woulda been dead.

Interviewed by Melissa Shook, November 1988, Long Island Shelter. (No contact with Marybeth after she left the shelter.) Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

And, then, I got into a relationship with a real winner. And he used to beat the daylight outta me. For about a year, I didn't even know what my face looked like anymore, because I always had a fat lip or a black eye or a broken nose and two black eyes. I put up with that and I thought it was 'cause he loved me that he did these things and that he was sick and that I could help him.

I couldn't even go in the doctor's office without him there. He sat right there, and he told me that he would kill me — and I believed him — if I said anything. Um, he was violent sexually and I took that kind of abuse. I was petrified to go near him. And then he got arrested. He went to jail and I left him. I never wrote or talked to him again.

And then about five months ago he escaped from Bridgewater [prison] and came looking for me with a gun and I was still into my drugs. This was right before I went to jail. And I was so scared that I stood in the parking lot where he saw me and I threw up because I seen the gun pointed at me and I knew he was crazy enough to kill me. Somethin' made him not kill me. I don't know what it was.

I had isolated myself so much from my family. I had, um, pushed everybody away because of him. I was afraid that they'd see what he was doin' to me and it would hurt them, and I didn't want to hurt them. So I would stay away.

I was ashamed of what I was goin' through because I was always raised to be strong and you take care of yourself and, you know, anything happens to you, it's 'cause you allow it to. And I was afraid that my family would see that I was weak. And I don't want them to ever see that. And I have a strong backbone and I can take on my own responsibilities and I know I am responsible for my own life and what happens to it.

[Recalling life as a drug dealer:]

I was always put on a pedestal because I was dealin' drugs b—ig time. I had my apartment, I had, you know, food in my house, I had a car. I had everything that showed off. I had the gold. I had the diamonds until the police broke in house and took everything from me and I found that I was just another person when I was layin' out there on the sidewalk in a towel with a cop's foot on the back of my neck. I realized right then that I was scared for the first time in my life.

I hate bein' in this place. I hate the fact that I'm down this low that I have to be here. I'm proud that I'm goin' to a halfway house Monday, but I'm scared to death too because I have to face . . . that — I am part of society and I do have to live right or I'm just gonna die. I don't wanna die — twenty-one years old. ♪

AIDS and the Homeless of Boston

James J. O'Connell, M.D.

Joan Lebow, M.D.

Homeless persons with AIDS and HIV infection face significant health hazards during the daily struggle for survival on the streets and in the crowded shelters of our cities. This article offers a historical perspective on the evolution of the AIDS epidemic within the homeless population of Boston and examines the demographics, risk behaviors, and survival statistics of that epidemic. The Boston Health Care for the Homeless Program is presented as a model of service delivery that offers quality health care to homeless persons with AIDS while addressing the special needs of those bound by the immediacy of the next meal and a night's shelter. Health care is inextricably woven into the fabric of social policy and cannot be delivered without an accessible network of housing, entitlement, job training, mental health, and substance-abuse services.

On Labor Day 1991, a *New York Times* cover article offered a sobering assessment of a tragic problem entering the second decade of national prominence and shame: "Shift in Feelings on the Homeless: Empathy Turns into Frustration." The good will of neighborhoods and cities has been eroded by the encroaching visibility of homelessness, the hard times of a national recession, and a public policy bereft of solutions despite an exuberant patchwork of emergency and transitional services. While answers to solving the problem are elusive, the causes of homelessness are more evident: poverty, lack of affordable housing, the disintegration of the nuclear family, poor education, and the disappearance of the low-skilled factory jobs that gave an opportunity for homes and education to generations of American workers and their families, and gave cause for past Labor Day celebrations.

Homelessness is the chasm below the social safety net, an abyss of abject poverty known to a heterogeneous cross section of society's most vulnerable citizens: families with children, runaway and throwaway adolescents, and single men and women suffering from chronic mental illness, substance abuse, physical or sexual violence, illiteracy, complex medical problems, the nightmares of war, or advancing years with

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meager financial reserves and atrophied gray matter. Most are without the support of family, neighbors, or community.

This article explores the effects of AIDS and human immunodeficiency virus (HIV) infection on this world below the safety net as witnessed by the physicians, nurses, and caseworkers of the Boston Health Care for the Homeless Program (BHCHP). Where possible, we have included the stories of people who have quietly and courageously borne this virus during the struggle to survive on the streets of the city. Understanding the magnitude of the problem and the special needs of persons with AIDS who have no homes is critical in formulating a humane public health policy.

The Beginnings of the Epidemic

Only one person with AIDS was known to be living in the shelters or on the streets of Boston when BHCHP began direct care services in the summer of 1985. This white homosexual male in his early forties, working at a moderate-wage job without medical benefits, lost both his employment and his apartment in the South End as a result of his illness, and humiliated and alone, he came to a 360-bed shelter in Boston. Despite the anonymity of the streets, shelter guests and staff soon knew this frail person's diagnosis, and uncomfortable community meetings at the shelter were required for several weeks to allay understandable fears of an infection largely unknown at the time. He was accepted into the shelter and cared for by a committed staff that allowed him to remain indoors on days when his fatigue or diarrhea were disabling. He died later that autumn, from complications of cryptococcal meningitis, in a nursing home not far from the shelter, where he was visited each day by friends from his new community.

During the next two years, twelve homeless persons were diagnosed with AIDS. At a time when over 80 percent of AIDS cases in the United States were among homosexual men, the demographics of this small sample foreshadowed an ominous shift in the epidemic: the spread of HIV infection to a heterosexual population, especially people with a primary risk behavior of intravenous (IV) drug use and those who have been sexual partners of IV drug users. Three (25%) of our initial twelve AIDS patients were women. Seven (58%) were persons of color: four Hispanics and three African-Americans. Eleven of the twelve (92%) had used IV drugs in the recent past.

All had histories of alcohol abuse, as evidenced by withdrawal seizures, delirium tremens, hepatitis, or admissions to detoxification units. Over half these people had been hospitalized for prolonged periods for serious mental illness. Fifty percent had been incarcerated for a year or longer. Efforts by BHCHP and shelter providers to offer primary care to this group proved Sisyphean, thwarted by the lack of housing, the fragmentation of services, and the dearth of substance-abuse treatment and rehabilitation programs. The first seven persons lived an average of only 5.3 months, and most were found dead in the streets — abandoned, alone, and without dignity. An unpublished BHCHP study found that these individuals had been admitted to an average of three different area hospitals for a total mean of 144 days in the year before death; the hospital costs per patient averaged \$84,000 in 1986 dollars.

Some of the stories illustrate the chaos. After six weeks in a hospital north of Boston, including several weeks in the intensive care unit in a coma, a young woman with AIDS was discharged at 2:00 A.M. by taxicab to a Boston shelter, a distance of

more than twenty miles. She arrived without information, medications, or follow-up appointments. Subsequent investigation revealed that this weak woman had exhausted the patience and resources of the community hospital and had been sent summarily to the shelter in exasperation. Demented at the age of thirty-four, ataxic and unable to negotiate stairs without assistance, and at great risk for bleeding because of a very low platelet count of less than 30,000, she could hardly have been placed in a more dangerous setting than the shelter. Two days later she fell in the shower, sustained a subdural hematoma (bleeding between the brain and the inside of the skull), and died after three weeks in the Boston City Hospital (BCH) intensive care unit.

A young man with chronic mental illness developed mild dementia and memory loss and was diagnosed with cryptococcal meningitis. The Department of Mental Health refused admission to a psychiatric facility because his HIV infection preceded any known mental illness, and his youth precluded Medicaid coverage for chronic care hospitalization. He was discharged to a shelter, where his erratic behavior became intolerable as he left bloodied razors in the bathrooms and frequently urinated and defecated in the common areas. He was barred from the facility and literally had no other place to go; throughout that winter he slept on the floor between the two glass doors of the shelter foyer. Eventually he was admitted to the AIDS Unit at the Lemuel Shattuck Hospital, a ten-bed facility for the chronic and terminal care of persons with AIDS, where, after several months, he died at the age of thirty-one. He had last seen his father at Children's Hospital, when, at the age of fourteen, he was having cardiac surgery; efforts to locate his family were in vain until a local investigative reporter was able to find the dead man's father: "I can remember him when he was real little, takin' him to the store with me. He was a real gentle little boy, nice little boy. Homeless! Ohmygod, no."¹

A thirty-year-old Hispanic man, well known to the BHCHP staff, was noted by an observant nurse in the shelter clinic to be acting unusual and having some difficulty walking. The nurse called the BHCHP physician, concerned that this could be related to HIV infection, and the man was sent to the BCH emergency ward for evaluation. During the four-hour wait to be seen, he left the emergency ward, unable to recall the reasons for his referral; the subtle findings of the shelter nurse had not been noted by the busy triage staff. He failed to return to the shelter, and was found in an abandoned car two days later, suffering from shock due to an overwhelming toxoplasmosis infection. He required several weeks in the BCH intensive care unit and died of multiple organ failure four months later in a chronic disease hospital.

Such stories were as commonplace as unfortunate, yet understandable in the context of a health care system ill equipped to understand homelessness and accommodate the special needs of this high-risk population.

Demographics

The Elusive Denominator

Estimating the size of the homeless population in the United States or in any particular city has been contentious and problematic, limited by the definition of "homeless," the transience of the population, and the logistical difficulties with sampling techniques.² The numbers have ranged from 250,000 to over 3 million.^{3,4} While many individuals and families throughout the country live in shelters and on the streets

and are thereby literally homeless, innumerable others are huddled on the edge of homelessness and living doubled and tripled up in small apartments and rooms. The exact number of such persons is impossible to calculate.

The BHCHP has cared for over 25,000 homeless men, women, and children since 1985; in 1990, 6,800 unduplicated homeless persons received direct health care and social services in almost 28,000 encounters. The yearly Boston census has revealed between 3,000 and 4,000 literally homeless persons on a given night during each of the past two winters;⁵ however, the BHCHP numbers in 1990 provide a basis for estimating the number of homeless people living in shelters or on the streets at some time during a full year. Since BHCHP clinics care only for homeless persons willing to accept health care, 6,800 represents well less than half the homeless population in Boston during a year. A more realistic denominator would be at least 14,000 to 15,000, indicating that the problem is far more extensive in Boston than previously thought.

Seroprevalence Data

Very little is known of the seroprevalence of HIV infection in homeless populations; virtually nothing is known of the natural history and outcome of those who suffer with this infection while living in shelters and on the streets. All studies to date have been either retrospective or cross sectional, without control groups, or without the ability to follow homeless persons with HIV infection over significant periods of time.

Torres retrospectively analyzed 169 men living in a congregate shelter in New York City and found a 62 percent HIV seroprevalence rate among those referred for testing. Of the men with HIV infection, 65 percent (62 of 105) identified IV drug use as a major risk behavior. HIV infection was associated with 90 percent of active tuberculosis (TB) cases diagnosed in that shelter. Stratification according to total time spent homeless correlated positively with the development of active TB, as those who developed pulmonary TB had been homeless almost twice as long as those who did not develop the disease (9.7 versus 5.4 months).⁶

A 1990 study by Zolopa found an HIV seroprevalence rate of 11 percent among 500 consecutive homeless persons seeking medical care at four community locations in San Francisco. Of the 56 persons with HIV infection, 58 percent had a history of current or past IV drug use.⁷

An analysis of blinded blood samples from 2,667 runaways aged fifteen to twenty in the Covenant House Clinic in New York City, from October 1987 through December 1989, revealed an HIV seroprevalence rate of 5.3 percent. Of the 95 seropositive adolescents willing to discuss risk behaviors, 10 percent (9 of 95) identified IV drug use. However, the risk assessments were limited to data available in the medical records, and the authors underscore the likelihood of significant underreporting of high-risk behaviors at the time of initial contact with health care providers.⁸

A review of inpatients with HIV infection in a New York hospital found that 13 percent were homeless. The hospital stays averaged 62 days for homeless persons, but only 40 days for those with homes ($p < 0.02$).⁹

Homeless Women and AIDS

Women comprise an increasing proportion of new AIDS cases in the United States. While women accounted for only 2 percent of the reported cases in 1985, this figure had increased to 11 percent in May 1991. Black and Latin-American women share

a disproportionate burden of AIDS in the United States. Although only 19 percent of all U.S. women are either black or Hispanic, 72 percent of reported female AIDS cases occur among these two minority groups.¹⁰ IV drug use is the main risk behavior for AIDS in women, associated with 71 percent of AIDS cases: 52 percent are IV drug users (IVDUs) themselves, and 19 percent are sexual partners of IVDUs.¹¹

Little detailed information exists concerning the natural history of AIDS among women, and even less is known about the course of the disease in homeless women. The impact of gender on disease outcomes or response to treatment is unclear, and specific barriers to care for women have not been elucidated. Data from the AIDS Clinical Trials Group suggest that only 6.7 percent of patients in federally funded national AIDS trials have been women.¹²

Many gynecologic conditions may be more common and more aggressive in the presence of HIV infection. Women infected with HIV have an increased prevalence of lower genital tract dysplasia and human papilloma virus (HPV) infection, even when compared to HIV seronegative controls who used IV drugs or were sexual partners of IVDUs.^{13,14} Candida vaginitis, which occurred in 50 percent of women with AIDS, was refractory to treatment in 9 percent of cases.¹⁵ Investigators from Walter Reed Army Medical Center found that 24 percent of HIV-infected women (7 of 29) had a history of chronic refractory vaginal candidiasis.¹⁶ Buehler and colleagues at the Centers for Disease Control presented data from a national cohort of 631 HIV-infected women which showed that 11 percent (70 of 631) developed candida vaginitis during the first year of observation.¹⁷ Homeless women may have an increased risk for sexually transmitted diseases (STDs) as well. In one study, women who live in shelters reported significantly higher number of sexual partners than those who had never lived in them.¹⁸

The increased incidence of cervical dysplasia and infections with HPV, candida, and STDs has concerned providers because many homeless women have long histories of physical and sexual abuse and often shun routine pelvic and breast examinations. The complex relationships among homelessness, domestic violence, and HIV infection have not been examined critically. Studies have shown that over 15 percent of women seen in primary care clinics have a history of physical or sexual abuse.^{19,20} The BHCHP clinical experience suggests that physical and sexual violence is substantially more common among homeless women.

HIV infection in women necessarily involves their children, both those directly infected with HIV and those affected by maternal infection. Cord-blood data collected in Boston and nationally have shown that the majority of births by HIV-infected women occur among ethnic minority groups, and predominantly in impoverished inner-city neighborhoods riddled by IV drug use and homelessness.²¹

AIDS and the Homeless of Boston

To assess the extent and effect of HIV on the homeless population of Boston, we retrospectively reviewed the BHCHP clinical records from July 1985 through March 1990. AIDS had been diagnosed in 40 persons, AIDS-related complex (ARC) in 86, and 44 individuals had documented HIV infection without symptoms. An estimated 200 other persons were identified with high-risk behaviors. A pilot study was then conducted of the 40 people who met the definition for AIDS of the Centers for Disease Control. Eighteen percent were women, while persons of color comprised 75

percent of the cohort (22 black, 7 Latino, and 1 Native American). Thirty-one persons (78%) gave a history of recent IV drug use. Twenty-two (55%) had died, and the mean survival of 10.4 months was similar to housed Boston residents with AIDS.²²

This latter finding seemed difficult to reconcile with our hypothesis that persons with AIDS living in shelters and on the streets are at significant risk for excess morbidity and mortality when compared to those having the stability and safety of homes. The equal survival rates are especially surprising in light of the original, albeit small, group of seven homeless persons in 1986 and 1987 who lived only an average of 5.3 months after diagnosis with AIDS. Most of the forty persons in the pilot study were diagnosed after 1987, a time when antiretroviral therapy and improved diagnosis and treatment of many opportunistic infections had combined to improve the quality of life and survival time of persons with HIV infection.

We have studied mortality among homeless persons in Boston during the past five years, and over 350 deaths have now been documented. Death certificates, BHCHP clinic records, shelter records, and BCH hospital charts were reviewed to determine the causes of death. Access to a broad network of services has facilitated case finding, and the study has continued into the sixth year. The deaths associated with HIV infection have increased during four years of data analysis, as shown in Table 1.

Table 1

Mortality and HIV Infection among Boston's Homeless

Year	Deaths	AIDS	ARC/HIV+	Total HIV-Related Deaths	
1986	56	5	2	7/56	(13%)
1987	53	1	2	3/53	(6%)
1988	68	4	5	9/68	(14%)
1989	73	14	7	21/73	(29%)
Total	250	24	16	40/250	(16%)

These data demonstrate the disturbing fact that many homeless persons with HIV infection die before progression to AIDS, and explain to some degree why the survival curves appear similar in the pilot study. Of the forty deaths among homeless persons with HIV infection in Boston, sixteen (40%) occurred before the infection had progressed to frank AIDS. Since only AIDS cases are reported to the commonwealth of Massachusetts, the true impact of HIV and related opportunistic infections on this population has certainly been underestimated, and the calculation of survival rates becomes far more complex.

Barriers to Care

The Experience of Homelessness for the Chronically Ill

The immediacy of survival on the streets is the primary concern and full time occupation of homeless people. Life must be lived in the present, with little time afforded the future. Several logistical problems face homeless persons who are ill. Shelters require guests to leave early each morning, with the doors opening again in the late afternoon. Waits in long queues are required to enter the shelter, obtain a bed ticket, and secure a meal. While they wander in search of refuge during the days, exposure

to the extremes of weather and temperature are commonplace. Public bathrooms are scarce and often locked to indigents. The shame and indignation voiced by our patients over recurrent and often explosive diarrhea is unimaginable. Fatigue and weakness are common constitutional symptoms that are magnified during the struggle to survive on the streets, especially for those who must carry all their worldly possessions during the daily journey. Inanition and malnutrition render homeless persons with AIDS prey to all manner of violence, especially on the first and third days of the month, when entitlement and Social Security checks arrive. Medications like zidovudine, formerly called azidothymidine (AZT), must be taken every four hours, a formidable challenge even to people with the stability of a home and a predictable routine. In addition, AZT and other medications have a high value on the black market and are frequently stolen or sold. Tuberculosis and other communicable diseases are common in the crowded, poorly ventilated, dormitory-style shelters that are characteristic of those found in larger cities.

AIDS Education and Prevention

Studies assessing AIDS awareness and knowledge among homeless persons have found that 80 to 95 percent of those responding to a questionnaire knew the high-risk behaviors associated with HIV transmission.²³ Findings from a New Orleans survey demonstrated an exceptionally high knowledge rate of HIV infection among homeless adults, yet 57 percent of those responding continued to share needles and 31.7 percent engaged in unprotected sex.²⁴ Such information underscores the difficulties of changing behavior in this population despite creative efforts at education and prevention. Drug sickness drives the behavior of the addict and renders future health concerns irrelevant as the heroin or cocaine and the "works" are cooked, passed, and shared. Education and prevention programs must recognize this reality of life for those addicted to drugs; programs that target people who continue to engage in high-risk behaviors will inevitably challenge the tolerance of a society that does not condone such behavior. Yet the reality is frightening, and millions of needles and bodies are shared each day in an HIV Russian roulette played by people suffering from the illness of drug addiction.

Condoms and bleach should therefore be readily available in a prominent but unsupervised place in every shelter. Many street workers and drug counselors have advocated needle-exchange programs as a small but important means of minimizing the spread of the virus while awaiting adequate numbers of treatment beds and potential vaccines against it.

HIV Testing

Evidence suggests that antiretroviral treatment is effective for persons with HIV infection whose CD4 lymphocyte counts are below 500, whether or not symptoms have occurred.^{25,26} Prophylaxis against *Pneumocystis carinii* pneumonia (PCP) has been shown to prolong survival and increase the quality of life for persons who have had previous episodes of PCP, and has become a mainstay of preventive therapy for asymptomatic individuals whose CD4 lymphocyte counts are below 500.^{27,28} Many other medications are likely to become essential in the early treatment of HIV infection, hence public health officials and primary health care providers should urge persons engaged in high-risk behaviors to seek HIV education, counseling, and antibody testing. The public health goals are straightforward: (1) through education and

behavioral modification, minimize further transmission of the virus by those infected; and (2) assure optimal quality of life and survival through primary and preventive health care early in the course of the infection.

Unfortunately, most providers of care to homeless persons with high-risk behaviors have wrestled with the paradoxical effects of HIV testing in this impoverished population with minimal supports. Two early BHCHP patients with HIV seropositivity, tested in correctional institutions with a minimum of counseling, committed suicide before the development of symptoms. One, arrested for petty shoplifting, was later resuscitated in his cubicle after an attempt to hang himself. A ten-day admission to an intensive care unit was followed by a two-week evaluation in a mental health facility. He returned to the streets, awaited his monthly veteran's check, and wrote a final letter of apology for "a wasted life" to his girlfriend and family before overdosing on heroin during Labor Day weekend of 1986. During many clinic visits, this former high school athlete spoke openly about his "descent into drugs" and confessed that he shared a death wish with other addicts who saw the virus as the only release from the drugs.

The other person, a heralded saxophone player in the big band jazz era, was in his mid-fifties. A heroin habit, dating to 1955, had eroded family and career while ushering him to the margins of single-room-occupancy (SRO) establishments and shelters. Brief clean and sober periods invariably brought full cognizance of life's losses and a simple acknowledgment that heroin was better than an awareness of his loneliness in a bare room with a shared toilet. He came to our clinic in early 1986 with questions about his positive HIV antibody test, obtained by a corrections facility while he was serving a short sentence for possession. His vision of AIDS, despite his own blessing of robust health with no constitutional symptoms, was limited to several emaciated and demented friends who had died utterly alone on the streets of New York. Our caseworker helped him obtain SSI benefits within a month and found him a two-room apartment in a downtown neighborhood. A trusting and convivial relationship had developed with the BHCHP staff, and he had managed to remain drug free for over three months. He was found dead in his apartment several weeks later from an overdose of heroin, a note on his sofa thanking us for the help.

If public health policy suggests HIV testing in order to change behavior and minimize the spread of infection, it must be acknowledged that the opposite generally results when homeless persons suffering from chronic opiate or cocaine dependence are tested. The most common response has been to embark on a drug run, to get high, and to escape. As one young woman with a seven-year cocaine habit told us, "My HIV test is negative, and I'm disappointed. The truth is, I'm not ready to deal with life without drugs, and a positive test would have given me all the reason in the world to use my drugs without worry. And the funny thing is, now that I'm negative, maybe I can just keep doing things the same way and be safe!" Her pattern had been to prostitute for her drugs, and she had never used condoms or bleach despite an advanced knowledge of HIV transmission.

HIV testing in a homeless population therefore poses ethical dilemmas that are often overlooked by an otherwise rational public health policy. High-risk behavior often escalates, and primary care becomes difficult and disjointed at best. Chemical dependency is a chronic and relapsing illness, a complex medical and behavioral puzzle that has not yet been successfully solved. When accompanied by the extreme

poverty and lack of community and family supports that are the hallmarks of homelessness, the illness is virtually untreatable. And the burden of a fatal illness like AIDS completes a triad that destroys all vestige of hope. To expect drug behavior to change in the midst of an agony and despair hardly imaginable to educated Americans with homes and families is simply unrealistic. Every housing, rehabilitation, or transitional program available to homeless persons with HIV infection in the Boston area requires sobriety, an understandable need to assure the acceptance, feasibility, stability, and maintenance of these innovative programs. Unfortunately, such supports become attainable only when most homeless individuals become too ill to hustle and support a habit, a time often far advanced in the course of the infection.

Homeless persons with HIV infection need a stable residence and routine in order to begin the process of recovery. The immediacy of the struggle for survival on the streets usurps all hope for addressing one's addiction, especially with the dearth of treatment beds in most large cities. Public health policy must recognize the reality of this condition; treatment beds must be available on demand, and new programs are essential to offer admission to homeless persons in order to help them address the issues of addiction *after* securing the stability of a regular residence.

The BHCHP Model of Care for Homeless Persons with AIDS

The Boston Health Care for the Homeless Program was one of nineteen four-year projects nationwide funded in 1985 by the Robert Wood Johnson Foundation and the Pew Memorial Trust. The mission of assuring available and accessible quality health care for all homeless families and individuals in Boston mandates that the BHCHP services become an essential part of the existing health care system rather than a separate or alternative system. Multidisciplinary teams of full time physicians, nurses, and caseworkers have become the focus of a service delivery system that integrates direct health care and social services in over forty shelter and outreach clinics throughout the metropolitan area with the primary care and specialty clinics of two major teaching facilities, Boston City Hospital (BCH) and Massachusetts General Hospital (MGH).

Primary care clinics for homeless persons are held four days each week at BCH, and twice a week at MGH. All homeless persons admitted to those hospitals are visited by BHCHP teams, who collaborate with the medical, nursing, and social service staffs to facilitate practical discharge planning and adequate follow-up.

A twenty-five-bed Medical Respite Unit operated by the BHCHP in the Lemuel Shattuck Shelter accepts direct referrals from area hospitals for homeless patients ready for discharge to a home with visiting nurse and home health aide support, but too ill to withstand the hazards of life on the streets. This unique model of cost-effective recuperation provides medical and nursing care in addition to assistance with entitlements and housing. Alcohol and other substance-abuse counseling is available in addition to Alcoholics and Narcotics Anonymous meetings. Physical and occupational therapy are provided; literacy classes have also been initiated in response to the high percentage of persons admitted who are unable to read and consequently have had great difficulty in the competitive job market. The average stay has been about three weeks, although for the 15 to 20 percent of admissions for HIV-related illnesses, this

approaches one month. The window of opportunity afforded by such a time of recuperation and concentration of services has resulted in the placement of almost one-quarter of these patients to permanent housing or long-term rehabilitation or transitional programs.

The BHCHP Family Team cares for women and children living in family shelters and safe shelters for women throughout the city; a family physician journeys with the nurse practitioners and family advocates to motels in an area from Peabody on the North Shore to Hull on the South Shore, where Boston families are often sent when the shelters are full. The Perinatal Team has followed women who have become pregnant while living in shelters in an attempt to engage them in early prenatal care and adequate nutrition programs.

Portable dental equipment allows the BHCHP dentist and dental assistant to provide comprehensive services several days each week at St. Francis House, a soup kitchen located in the heart of Boston's Combat Zone. Services are also brought directly to families and adults in several other shelters on a rotating basis.

In response to the intensity and burden of the escalating HIV epidemic in the homeless populations, BHCHP has evolved significantly while trying to address the needs of those served. The care of these patients requires lengthy and frequent clinic visits for education, prevention, management of medications, and the early diagnosis and treatment of opportunistic infections. Existing funding streams do not allow for such intensity of care, and community health centers and hospital clinics have been understandably reluctant to manage "difficult" and uninsured homeless HIV-infected patients.

Two BHCHP physicians, two nurse practitioners, and a Hispanic caseworker conduct weekly sessions in the BCH AIDS Clinic, a multidisciplinary specialty clinic for persons with symptomatic HIV disease. This collaboration has allowed for full access to state-of-the-art care for homeless people with AIDS, including participation in all appropriate clinical trials and experimental protocols. The BHCHP staff has been able to keep abreast of the changing medical management and approaches to HIV infection, and primary HIV care is thereby brought to homeless persons throughout the network of shelter clinics. All those eligible are offered antiretroviral therapy with AZT, pneumonia and influenza vaccinations, and prophylaxis against tuberculosis (isoniazid, rifampin) and *Pneumocystis carinii* pneumonia (trimethoprim-sulfamethoxazole, dapsone, or aerosolized pentamidine).

The Continuum of Care and the Network of Services

The experience of the BHCHP has emphasized that health care is inextricably woven into the socioeconomic fabric of society, and the effectiveness of this model of care depends entirely on access to an array of services provided by private and public agencies, especially housing, entitlements, welfare, substance-abuse treatment, and mental health services.

The Futility of the Traditional Medical Model

The health care of homeless persons can be fragmented and futile for patient and provider. An illustrative scenario may be helpful.

A caring social worker notices a fatigued and cachectic-appearing young IV drug user in a soup line. A taxi voucher or subway token is given to provide transportation to the nearest emergency room, where he waits several hours to be seen. Indeed,

this problem is more chronic than acute, and far less emergent than the trauma or heart attacks or drug overdoses that overburden the staff of such facilities. When finally seen by an exhausted intern, the man is scolded for coming to an emergency room and reprimanded for failure to seek primary care for his chronic problems. An open sore is noted on one foot, and the treatment plan calls for a prescription antibiotic to be taken four times a day for ten days, elevation of the foot during the next several days, and dressing changes three times a day. A follow-up appointment is given for two weeks hence in primary care clinic.

Many hours have passed. Transportation to a shelter has not been provided, the evening meal is finished, and no more beds are available for the night. He has no money to buy his prescription, and he would be unlikely to remember to take it four times a day. Elevation of the leg and dressing changes are impossible while wandering the streets during the days while the shelters are closed. Despite the proper diagnosis and the textbook treatment plan, this painful encounter with the health care system too often results in a prolonged and costly hospitalization for a life-threatening cellulitis of the lower extremity.

The Changing Topography

AIDS has blurred the traditional boundaries within internal medicine. This retrovirus, once thought to be the rarefied domain of microbiologists and infectious disease specialists, became of vital interest to oncologists when identified as a probable factor in cancers such as Kaposi's sarcoma and non-Hodgkin's lymphoma. With advancing clinical and laboratory knowledge, the virus has involved virtually all of the medical specialties: cardiology, hematology, nephrology, psychiatry, neurology, dermatology, pulmonary medicine, and many others. Primary care physicians and specialists have found that full collaboration is the only effective treatment and management strategy for the care of persons with this unusual infection.

The AIDS Clinic at BCH is staffed by oncologists and infectious disease specialists as well as internists and nurses. Nutrition services, psychiatric care, support groups, addictions counseling and placement, on-site staff from the AIDS Action Committee and the Massachusetts Rehabilitation Commission (responsible for SSI/SSDI in the commonwealth), a dedicated chaplain, and energetic social service advocacy for housing and entitlements represent some of the services offered in the clinic. A philosophy of highly involved and personalized care has evolved in this clinic.

This metaphor extends to the larger network of health and social services, in which traditional boundaries and "turf" issues have been challenged by the epidemic. HIV infection is a chronic illness that waxes and wanes in unpredictable cycles; persons who are severely ill and near death with PCP can recover and return to a productive life. The health care system must recognize the continuum of this disease process and provide a variety of treatment facilities that address the changing needs of those to be served. An example of one of the Medical Respite Unit patients illustrates the need for a range of accessible and flexible services.

A forty-year-old black male was admitted to BCH for elective knee surgery. The anesthesiologist noted oral thrush during preoperative evaluation. The surgery was postponed, an HIV antibody test drawn, and the patient was discharged to a local shelter. The following morning the patient was seen at Project TRUST, an anonymous HIV counseling and testing center on the grounds of BCH, and an alert staff member brought him to the Homeless Clinic at BCH. Despite attempts to establish

a primary care relationship, he was lost to follow-up until two months later, when he was intubated and admitted to the intensive care unit with fulminant PCP. He recovered uneventfully and was discharged to the Medical Rescue Unit (MRU), where oral Bactrim therapy was continued and the patient was begun on AZT with careful monitoring. He enrolled in an on-site drug and alcohol treatment program. The BHCHP caseworker assisted him with SSI and housing applications. After returning to his original shelter, he continued to see his BHCHP team in the clinic on site as well as in the AIDS Clinic. He attends an AIDS support group each week, and receives aerosolized pentamidine every other week at the Fenway Community Health Center. After an adverse reaction to AZT, he was enrolled in the phase I trial of dideoxyinosine (DDI). Weeks after receiving housing, he became ill with tuberculosis and required a chronic hospital stay for several months.

Essential Services and Practical Pitfalls

Substance-abuse Treatment

Nearly 80 percent of homeless persons with AIDS in Boston have identified IV drug abuse as a major risk behavior. The lack of treatment beds on demand delays the primary health care needed by many homeless persons with HIV infection and reverberates on other emergency services. For example, the time between receiving a positive HIV test result and the institution of primary care treatment has averaged fourteen months for all patients entering the Diagnostic Evaluation Unit at BCH. The major factor appears to be continuous substance abuse, lending further credence to concerns over HIV testing in this population. The BHCHP experience suggests that acute care hospitalization or admission to a drug treatment program are the most common precipitants of entry to primary health care. Substance-abuse services must recognize the chronic and relapsing nature of this illness, and the availability of various modes of treatment is essential. Many patients continue to come regularly to scheduled appointments despite daily drug use. Detoxification is urged and offered at each visit.

Methadone maintenance continues to be an important treatment for opiate dependence, despite a frequent acceleration in the use of cocaine, methadone-enhancing substances (such as Xanax and perhaps Prozac), and alcohol. Unfortunately, these polysubstance-abuse problems are further complicated because most detoxification units refuse to maintain patients on methadone while they are withdrawing from alcohol, cocaine, and other substances.

Andrew House Dual Diagnosis Detoxification Unit on Long Island in Boston Harbor has provided care for polysubstance abusers, many of whom have chronic mental illness. Methadone can be maintained during detoxification from other substances, and many patients are admitted for withdrawal from methadone after varying periods of maintenance therapy. More than half the admissions are referred from area shelters, and many have HIV infection. A strong nursing component has assured that complex medical issues can be monitored, while mental health and behavioral issues are overseen by the staff psychiatrist. A variety of treatment modalities is offered, including Alcoholic and Narcotics Anonymous as well as individual and group counseling. Many patients return for several admissions before achieving significant periods of sobriety, and the staff is aware of providing a secure and welcome place for those who repeatedly fail.

Housing and Entitlements

Affordable housing is obviously essential if the problem of homelessness is to be solved. The issue has been eloquently addressed elsewhere in this journal. Equally obvious, homeless persons with AIDS need the same continuum of housing options as other persons with AIDS, including independent living, group and shared homes, infirmaries or respite care centers, acute and chronic care facilities, and hospices.

Efforts to deliver quality health care are hampered by the delay in obtaining entitlements and housing. SSI regulations recognize only the Centers for Disease Control AIDS-defining diagnoses as sufficient evidence of permanent disability, despite the fact that many persons with chronic fatigue and other constitutional symptoms are too incapacitated to engage in gainful employment. Unfortunately, housing often comes too late in the course of the infection, or as one BHCHP patient complained during the public hearings for the Ryan White Act, "Why do you wait until I get sick before you give me the housing and stability I need to keep myself healthy?"

Another chronically homeless man waited a full year for housing after his diagnosis of AIDS. During that time he was hospitalized several times for PCP, esophageal candidiasis, pneumococcal pneumonia, herpes simplex virus, anemia, a nonhealing leg ulcer, and several episodes of high fevers without a known source. At the MRU, the caseworker finally located an apartment for him, although he died only a few months afterward.

Finally, housing is necessary but not always sufficient for homeless persons with AIDS. Many have been chronically homeless, and some have never owned or rented a room or apartment. Some individuals have asked to die in the familiarity of the shelter or the Respite Unit, fearing to face an unknown alone. Others are anxious for places of their own, but are without the skills necessary for independent living. One young man, who obtained a studio apartment, sullenly brought his \$4000 phone bill to his physician in the AIDS Clinic. He suffered insomnia, and responded to late-night television commercials by calling 900 numbers to talk to someone and assuage his loneliness and fear, unaware of the exorbitant costs of these alluring businesses.

Future Policy Considerations

The human faces of homeless persons with AIDS have been blurred by the epidemic's overwhelming statistics, strained by the "compassion fatigue" of a society increasingly exasperated by what it regards as the "undeserving poor," and hidden within the shadows of urban gentrification. The stories recounted here illustrate an eclectic and complex problem with few stereotypes. No single solution to homelessness will be the panacea, just as no single vaccine is likely to prevent the constantly mutating human immunodeficiency virus. Solutions to homelessness will be forthcoming only when society resolves to care for its least fortunate citizens, those with hope shattered and choices limited by poverty, unemployment, fractured families, violent neighborhoods, decimated school systems, and a dearth of affordable housing.

The Hydra of homelessness, substance abuse, and HIV infection presents a daunting challenge to the public health and social welfare. Science and society have yet to implement the cure for any of these; homeless persons with HIV infection and chemical dependency suffer an unimaginable burden. Public policy must recognize the plight of those on the fringes of a suspicious and frightened society.

We believe that the Boston Health Care for the Homeless Program offers a unique model for the effective delivery of state-of-the-art health care to homeless persons, especially those with HIV infection. The collaboration of public and private agencies, shelter providers and teaching hospitals, and the various professional disciplines has allowed the care of a person in a street clinic to be fully integrated into Boston's established health care network. The funding streams of the BHCHP are consonant with the mission of the agency and mandate the program to evolve continually to meet the changing needs of those to be served.

The evolution of the AIDS Program of the BHCHP, for example, has been in response to a need that was essentially nonexistent in 1985. Homeless persons with AIDS require a continuum of care, a series of fully accessible and readily available health care "stations" during the course of the infection: forty shelter clinics, primary care clinics at BCH, MGH, and Lemuel Shattuck Hospital, BCH AIDS Clinic, inpatient care at several hospitals, Mattapan Chronic Disease Hospital AIDS Program, the Medical Respite Unit, Project TRUST, Andrew House and other detoxification units, BCH and Bay Cove methadone clinics, the AIDS Action Committee, Paul Sullivan Housing Trust, Seton Manor AIDS housing program, the Mission Hill Hospice, and countless others. AIDS is a chronic illness with a variable clinical course, and each of these "stations" is an essential component in the array of services needed to meet the particular needs of individuals during varying degrees of health and illness.

Yet the very success of this program begs the uncomfortable question: Is this just another Band-Aid approach, a salve for a complacency of a society unwilling to implement the fundamental changes necessary to eradicate persistent poverty? We applaud those volunteering as "points of light" in the darkness, but they hardly substitute for the political will and leadership required for change and enlightenment in the health and human services in this country. BHCHP has not used volunteer physicians and nurses, because homeless persons voiced a desire to be treated as other Americans are, with an identified and easily accessible primary care doctor; hence, seven physicians are employed full or parttime by the program, and all remain active on the staffs of the teaching hospitals and associated medical schools.

Fundamental change at the policy level will require both the blurring of institutional boundaries and the abolition of categorical funding streams. The myriad of agencies designed to address the basic needs of a single individual is as bewildering as the bureaucracies are Byzantine. The health of a homeless person with HIV infection requires adequate housing (Boston Housing Authority, U.S. Department of Housing and Urban Development), access to entitlements (Massachusetts Rehabilitation Commission), welfare and medical insurance (Department of Public Welfare), primary and specialty medical care for the uninsured (Department of Medical Security), and access to substance-abuse (Department of Public Health) and mental health (Department of Mental Health) treatment facilities.

The many programs working to meet the needs of homeless persons with AIDS and HIV infection have demonstrated effective strategies for delivering quality health care and social services. Without the fundamental commitment of society to care for those most in need, however, these are only Band-Aids on a festering and gangrenous wound. ■

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Let Them Have Housing

Wendy Quinones

Does eliminating homelessness primarily require social services or affordable housing? Research done among former guests of the family shelter operated by Wellspring House, Inc., suggests that, at least for one group of homeless mothers, the provision of secure and affordable housing enables them to function and even to flourish. This article explores both the research and its philosophical underpinnings.

How can we eliminate homelessness? Do we need a wide array of social services for people so dysfunctional that they cannot by themselves either acquire or remain in housing? Or do we simply need an adequate supply of housing affordable to those of limited means?

These two approaches, grossly oversimplified in my descriptions, represent two sharply conflicting views of the causes of and solutions to homelessness and, indeed, poverty itself. On the one hand is the traditional American view of poverty and homelessness as the result of personal characteristics. This view usually holds that, as Katz describes it, "poor people think, feel, and act in ways unlike middle-class Americans. Their poverty is to some degree a matter of personal responsibility, and its alleviation requires personal transformation, such as the acquisition of skills, commitment to the work ethic, or the practice of chastity."¹

On the other hand is the view that poverty is the result less of personal failings than of economic and social forces. This view holds that, again according to Katz,

poverty, after all, is about distribution; it results because some people receive a great deal less than others. Descriptions of the demography, behavior, or beliefs of subpopulations cannot explain the patterned inequalities evident in every era of American history. These result from styles of dominance, the way power is exercised, and the politics of distribution.

Poverty no longer is natural; it is a social product. As nations emerge from the tyranny of subsistence, gain control over the production of wealth, develop the ability to feed their citizens and generate surpluses, poverty becomes not the product of scarcity, but of political economy.²

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In other words, poverty “is not an anomaly of the affluent society but the outcome of massive economic trends.”³

The policy implications of these analyses are profound, and again, sharply contrasting. If, after all, we see homelessness and poverty as matters of personal characteristics, it follows that we must try to change those characteristics if persons are not to be homeless or poor. If, on the other hand, we see homelessness and poverty as a result of political and economic forces, we must try to change forces rather than persons.

Obviously, reality is not so simple. Just as there is no single type of homeless person, there is no one analysis of homelessness that will provide a single solution to the problem. One thing that has been largely missing from the discussion, however, is data about results of programs that have solved the problem for some fortunate individuals: programs that have helped homeless people find permanent housing. What services were required for them to find housing? What happened to them once they found it? Were they able to stay in it, or did their personal problems so overwhelm them that they became homeless again? How successfully did they manage their lives once they had secure housing? What were their hopes, dreams, and plans?

To date, there has been no systematic research to answer these questions. However, one research project recently completed by Wellspring House, Inc., provides some provocative information about at least one group of homeless people. Wellspring’s survey (which will be described in greater detail later in this article) of seventy-nine of its former guests — once homeless women with children — showed that:⁴

- Lack of affordable housing at the time these women needed it was the universal cause of their inability to secure permanent homes for themselves and their children. Physical abuse by husbands, boyfriends, or family members was the most frequent factor causing them to leave their previous housing situations.
- The overwhelming majority (91%) of these families moved from Wellspring’s family shelter to subsidized housing.
- Virtually all (94%) remained stable in permanent housing once it was affordable.
- Median age of the guests was twenty-five, average age twenty-seven.
- Nearly three-quarters have graduated from high school or earned high school equivalencies.
- Eighty-two percent have preschoolers.
- Over three-quarters have two or fewer children.
- Over three-quarters received full or partial AFDC benefits.
- Half of all respondents, and three-quarters of those with children out of diapers, were either working or in school.

At a time when many individuals and institutions within the mainstream homeless service-provision industry are pushing for “transitional” or “service enriched” housing to cater to the assumed needs of “dysfunctional” homeless women and their children, this research and the accomplishments of Wellspring’s former guests themselves suggest a dramatically different picture of what homeless families truly need.

Wellspring and Its History

Because both the idea for the study and the methodology grew directly out of the nature of Wellspring's philosophy, its shelter, its services, and its guests, it is necessary to describe them in considerable detail.

Wellspring House, Inc., one of 103 shelters in Massachusetts receiving state funds for serving the homeless, is a private, nonprofit organization dedicated to providing safe shelter and affordable housing to homeless people. Rather than merely providing services, however, Wellspring works both to empower its guests to achieve their own goals and to educate both the homeless themselves and the broader community about homelessness and its root causes.

Wellspring was founded in 1981 by six women and one man who bought a large house in Gloucester, Massachusetts, to serve both as their own home and as a place in which they could offer hospitality to people in crisis. Three of the founders continue to be active in the daily affairs of the house: Nancy Schwoyer and Rosemary Haughton still live there, and Mary Jane Veronese is a full-time staff member.

At first, Wellspring served any person in crisis (except active substance abusers and the severely mentally ill): teenagers alone, single parents, couples with or without children, and older individual men and women. By 1985, however, it became clear that the overwhelming need on Boston's North Shore was for a family shelter, and since then all of Wellspring's guests have been homeless families, virtually all headed by women alone.

Wellspring's population reflects the area in which it is located. Most of its guests come from the Cape Ann communities of Gloucester, Rockport, Essex, and Manchester-by-the-Sea, and from the town of Ipswich and the city of Beverly (smaller numbers come from other communities on Boston's North Shore, such as Lynn, Salem, and Peabody). Like the communities they come from, Wellspring's guests are overwhelmingly white: among the 152 guests named in its records (it has housed a good many more on a transient basis, for whom no records could be found), Wellspring has housed 6 African-Americans; of the 79 research respondents, the only 2 nonwhites were Hispanic. Likewise, the homeless families that have come to Wellspring are almost exclusively headed by women; only one of the respondents was a man.

The greatest number of Wellspring's guests have come from Gloucester, the largest Cape Ann community with a population of 28,000. While all the Cape Ann communities have suffered over the last decade, Gloucester has been especially hard hit by economic changes. Both its largest industries, fishing and tourism, are seasonal, and the fishing industry is declining; the city lacks large businesses and has a disproportionate number of low-paying service jobs. Unemployment rates are higher than the state average; the average Gloucester family earns 16 percent less than the average family in Greater Boston, and less than the national median income. A declining wage base and a dramatic appreciation of real estate values during the 1980s combined to create a large and growing population of those who cannot afford housing. The housing authorities of five communities (Gloucester, Rockport, Essex, Ipswich, and Manchester-by-the-Sea) own or manage 1,088 occupied units; they hold nearly double that number of households on waiting lists, but they can find neither affordable land for new housing nor funds for rehabilitating existing units.

Wellspring has responded to the problem not only by sheltering people in need, but also by creating affordable rental housing. It operates a six-unit apartment house (two apartments there are used as extra shelter space) and a ten-unit rooming house in Gloucester, both of which it bought and renovated. It also spearheaded formation of Wellspring Community Land Trust, a separate corporate entity devoted to creating affordable, limited-equity housing.

Wellspring and Its Guests

Wellspring is located on Route 133 in West Gloucester, in what was once an inn called the Stage Coach House. Built as a private home in the seventeenth century, the structure housing Wellspring's family shelter is now licensed as a lodging house. It has facilities for seventeen residents, including ten bedrooms. Usually five to six homeless families, who stay for periods lasting from several weeks to several months, and two staff members live in the house at any one time.

Inside and out, Wellspring House looks more like a private home than a shelter. Guests have a private bedroom (or more, if their family is large) to share with their children. There is a well-stocked playroom indoors and a very attractive play yard outside.

Much of the house retains a warm, seventeenth-century character, with wide plank floors and brick fireplaces. Lunches and dinners, prepared mostly by volunteers in the simple, homey kitchen, are eaten communally by guests, staff, and volunteers in a large, light sunroom. Guests are responsible for the cleanliness of their own rooms; general housekeeping chores are rotated among the staff and guests.

Within this homelike atmosphere, however, the shelter does provide a structured environment for its guests. They are required to abide by house rules: rising and breakfasting by 9:00 A.M., 11:00 P.M. curfew, mealtimes, and children's bedtimes are all specified. Parents' supervision of their children is required; any type of physical punishment is prohibited. Saving and budgeting, including repayment of any outstanding debts, are required, and guests work out strategies for this purpose with their caseworker; private consumption of alcohol is prohibited; any guest whose behavior gives rise to suspicion of drug or alcohol abuse may be asked to leave.

Guests trade adherence to these rules — although not always agreement with them — for a wide range of services. Because Wellspring's major focus is to help them find permanent housing as soon as possible, its guests' first staff interview is with the housing search specialist. This interview begins the process of determining the appropriate housing category for each guest, with special efforts to place them in priority categories of homelessness⁵ so that they can get rental assistance quickly. Thereafter, guests meet individually with the housing specialist as needed, resolving questions of where they want to live and what kind of documentation is necessary for housing assistance, among others. Guests also meet weekly as a group with the housing specialist to discuss information and issues like the process of applying for and receiving rental assistance, looking for an apartment, recognizing legal and illegal questions from landlords, being a responsible tenant, sensing discrimination, and being aware of their rights as tenants.

But Wellspring recognizes that housing is often not the only issue in its guests' lives, and it provides services to help in these other areas as well. Upon arrival, guests are assigned to a caseworker who meets with them individually at least twice a week

to help establish or clarify personal goals and methods of reaching them. Guests may turn to their caseworker in any situation of need: for help with such matters as budgeting, parenting or other family issues, direct advocacy with social service agencies, educational placements for themselves or their children, referrals to medical, legal, mental health, child care, or day care services, and so forth.

At the time of the survey, summer and fall of 1990, guests were also required to meet weekly with Wellspring's family life advocate in a support group to discuss such areas as early childhood development, nutrition, mental health, sexuality, domestic violence, welfare, and so on. Since then, a weekly session of a more formal Life Skills Group has been added, in which experts from the community lead discussions in their individual areas of expertise.

Wellspring's Philosophy

Wellspring has never been located within the mainstream of the movement to alleviate poverty. It is not an overtly or denominationally religious organization — its staff, volunteers, and board members express every variety of religious belief and disbelief — but Wellspring's founders were Catholics, and several locate their political beliefs within their interpretations of their religious tradition. Says Schwoyer, formerly a religious educator, "Our understanding of our religious tradition, being rooted in justice, allows us to find a framework." Haughton, a much-published feminist theologian, adds, "We were very influenced by liberation theology. There's a paradigm of the liberation of people from oppressive situations, starting with Exodus: the aim of God being the liberation of oppressed people."

To be sure, Wellspring provides many personal growth and development services of the sort a more social work-oriented, mainstream organization would. But within the mainstream, as Katz says, "discourse about poverty, whether liberal or conservative, largely stays silent about politics, power, and equality."⁶ So Wellspring's founders and staff see themselves as part of a different system of values and, therefore, policies.

"Justice is the thing we work out of," explains Schwoyer. "We work for systemic change, not personal change . . . We have to provide help with personal development, because the women have been so damaged by an unjust system. Yes, they need appropriate therapy — but it's been a struggle to find the right kinds of doctors and therapists who won't injure them further." And in providing even these services, adds Veronese, "we look at why services are needed, what's happening in the world that makes the services necessary."

Wellspring also encourages its guests to examine that world themselves, and to challenge traditional assumptions: to begin seeing themselves less as personal failures and more as normal and equal people subject to destructive forces larger than themselves.

Life at Wellspring makes demands on guests based on the assumption that they are competent, equal adults. Former guests frequently complained during the research interviews that the house rules are too strict, and that the demand for full compliance comes too hard on the heels of the chaotic situations many have just escaped. But the staff see their high expectations as a way of changing how their guests see themselves. "We are calling the women to a certain level of performance in the house," says Schwoyer. "Even that's empowerment."

Current guests petitioned the staff to allow them use of the house phone, rather than

the pay phone, for long-distance calls. They also requested that staff, with an in-house copier available, do the seemingly endless copying necessary for their housing subsidy applications. Both requests were refused. "We're calling people to be equal," declares Veronese. "They have to learn to live their lives, to figure out how much money they'll need for a phone call, how much copies cost, where to have them made, and how to get there." "Institutionalizing these services is what keeps people down," adds Schwoyer. "It looks benevolent, but really it is to separate them from the general population."

The Project and Its Participants

The idea for its research project grew out of Wellspring's plans for a tenth-anniversary celebration. Along with a year-long series of events like talks, parties, plays, and concerts, Wellspring's staff and board of directors decided to evaluate its previous ten years and begin planning programs for its next decade.

"They were, however," Haughton relates, "well aware of programs, developed by both social service agencies and nonprofit organizations, that were well meant but produced little result beyond resentment and misunderstanding on the part of both those who offered and those who received — or did not receive — such services. They did not want to repeat those mistakes. But what did the former guests really need? The simple, normal, and respectful thing to do to ascertain a person's needs is to ask. This is what Wellspring, as a body, decided to do."⁷

With many former guests in close proximity, Wellspring chose face-to-face interviews as the best means of obtaining information and opinions from them. With the help of consultants, Wellspring developed a questionnaire, hired researcher Helen Hemminger, trained volunteer interviewers, and located seventy-nine former guests willing and able to participate in the study.

This group represented a good cross section of Wellspring's typical guests. Those who stayed in touch with Wellspring did so for a variety of reasons: some were stable enough to be at the same address they had when leaving, while others continued in need of the support services Wellspring provides. Those who stayed at Wellspring for any length of time were likely to form strong and mostly positive feelings about it. Even those who had negative feelings about Wellspring were eager to participate in the study to offer opinions about how the shelter could be improved. Local former guests who did not remain in contact with Wellspring could usually be located for the purposes of this study through other connections.

The only types of guests likely to be underrepresented in the research group are those who were either not local to begin with or who had moved away, those who had left Wellspring because of substance abuse, and those who had been sheltered on a transient basis. These former guests were less likely to have formed strong ties to either Wellspring or the community; whether they were less stable and more prone to bouts of homelessness is not known. There was, however, a group of people who were contacted and did not participate in the study. Four refused; seven were unable to arrange the interviews.

But volunteers were able to contact and interview 79 out of the 140 former guests for whom Wellspring had recent addresses. Also, three focus groups were held, with five to eight interviewees and a facilitator at each discussion. Responses to the questionnaire and comments in the discussions were compiled and subjected to both qualitative and quantitative analysis.

The Research

Until they experienced it themselves, the respondents saw homelessness from the same distance as many in the general public, and held the same stereotypical beliefs about homeless people. Said one, "I never understood [homelessness] before it happened. I was one of those who thought it could never happen to me. I used to think homelessness was for drunks, for people who don't want to work."

This research, however, demonstrates that at least the homeless women who stayed at Wellspring confound the stereotypes in every way. As one woman declared, "We have brains. We are like you. The only difference is that our families fell apart. If your family fell apart, then you run the risk of becoming homeless, too."

Demographics

A summary of the demographic characteristics of our research group has already been presented. More detailed information follows.

Total number of respondents: 79

Exit dates from Wellspring House: Two-thirds stayed at Wellspring in 1987, 1988, and 1989

Ethnicity and gender: 97 percent white, 99 percent female

Age: Median, 25; average, 27; 20 percent under 21, 50 percent under 25, 13 percent over 33

Marital status: almost half were single, one-third were separated or divorced, 12 percent have married since leaving Wellspring

Education: 72 percent graduated from high school or earned a GED.⁸

Highest Grade Completed	Number	Percent
8	1	1
9	2	3
10	7	9
11	12	15
12	22	28
GED	14	18
Some college	13	16
Two years college	7	9
Four years college	1	1

Number of children: Over 40 percent had one child; over three-quarters had no more than two children; no one had more than four; two never had children; one had grown children

Age of youngest child: Eighty-two percent had preschool children; nearly half had children two and younger

Residence: Fifty percent lived in Gloucester, 15 percent in Beverly, 13 percent in Salem, and all but three in the North Shore area; 80 percent of current Gloucester residents grew up there.

Welfare status: Of those responding to income questions, 61 of 78 (78%) were currently receiving AFDC. Ten of the 61 were receiving only partial AFDC (between \$40 and \$378 per month instead of the minimum for one child of \$446 per month) because they were living with a boyfriend or husband and collecting partial AFDC for a child not fathered by him, or because they were working part time in a taxable job. Ninety percent of the married people were off welfare. Three individuals had no children under eighteen and were receiving other types of welfare benefits.⁹

Reasons for Homelessness

For all these women, the basic reason they became homeless was that at the time they were forced to leave one housing situation, they were unable to afford another. But homelessness was, for most of them, the culmination of a long, sad series of events; most had lived in several temporary situations before actually becoming homeless. As one respondent said, "Lots of things cause homelessness. Everyone has a story to tell."

Their perceptions varied about their own roles in their predicaments, mirroring the split among social theorists over whether the causes of homelessness are individual or societal. In a focus group, one laid the blame on economic shifts in the housing market: "Housing has to be more affordable. I mean tons more affordable. Normal everyday jobs should be enough to buy a house."

Another blamed herself: "I'd say we did bring it on ourselves, not intentionally, but by not finishing school, or by depending on a man."

But the first was quick to respond: "That's not right. I'm not a lost cause. I think the world has to change, not me personally."

In interviews, respondents were asked where they had lived before coming to Well-spring and to describe the circumstances that brought them there. Individually, the stories showed that for most respondents, lack of their own separate housing, which they couldn't afford, and lack of long-term family support caused them to seek out a shelter.

For example, "I was living with my mother, who was an alcoholic. She asked me to leave. Then I was living with my sister, but her place was unsafe and unsanitary; the board of health intervened. I couldn't stay with the father of my baby because he was abusive."

Or, "I was living with my son's father and he left. He wasn't paying the rent anyways. I came home because I needed help with my son, who was hospitalized. I lived at my brother's for about three weeks but it was too hard with the baby in that place. I moved in with my mother, but my stepfather was prejudiced against blacks [son's father is black], and the room they had me stay in had no heat."

Asked to choose the primary cause of their homelessness from a list of possibilities, respondents selected abuse by either family members or boyfriends more than any other reason. Eviction, either by formal proceedings or by request, was a close second choice. Their responses are tabulated below.¹⁰

Category	Percent
Abuse	27
Eviction	22
Separation	14
Pregnancy	11

Overcrowding	9
Fire	3
Lost job	3
Unit off market	2
Other	9

After Wellspring

Subsidized housing. For the vast majority of respondents, the availability of housing subsidies is the most important factor in being able to afford permanent housing. (Indeed, the relative availability of subsidies also determines to some extent how long guests typically stay at Wellspring. From 1981 to 1986, stays were usually six months to a year, because subsidies were unavailable and apartments were out of reach for those without full-time jobs. From 1987 to 1989, subsidies enabled 90 families to move from Wellspring to permanent housing in periods ranging from three weeks to four months. In 1990, cutbacks in the state subsidy program again meant longer stays for guests.) Among respondents, 72 of the 79 (91%) had either a federal housing subsidy (Section 8), a state housing subsidy (Chapter 707), or an apartment in a building subsidized by either the state or federal government (public housing).¹¹ Most had obtained their subsidies while staying at Wellspring (five respondents had left Wellspring without subsidies, but four of the five now had them).

Having stable housing has made a critical difference in the lives of these women. Still, many worried about becoming homeless again. They valued their housing highly (when asked about goals at the time they were in the shelter, 95 percent said an apartment or a place to live), and were acutely aware of being at the mercy of the prevailing political winds. Said one, "The most important thing I learned at Wellspring House was to have a stable home. I got a nice apartment. I'm going back to school. I'm getting my life back together. Now with the budget cuts, what are we supposed to do, become homeless again?"

Unsubsidized housing. Seven of the 79 respondents (9%) lived in unsubsidized housing. Only one, however, a full-time nurse, had earned her way out of need for a subsidy. Of the others, one never had subsidized housing, one was evicted from subsidized housing, two left subsidized apartments to move in with their boyfriends, one moved out of state for a time, and one relinquished both her apartment and her housing subsidy so her daughter and granddaughter could have them.

Second homeless experiences. Overwhelmingly, these respondents have remained in permanent housing; only five (6%) had a second homeless experience after leaving Wellspring. Two of these continued to be homeless after leaving Wellspring, stayed in a variety of temporary situations, and were able to secure a housing subsidy after entering a second shelter. A third woman became homeless again when separating from her husband. For at least two of the five, alcoholism was the major cause of their second bout with homelessness. One young woman who has experienced much homelessness describes what happened:

Basically, I was homeless since I was thirteen. I haven't had a regular steady place to live. The root of homelessness throughout my life has been alcoholism or drug addiction. I lived at Wellspring when my mother and stepfather split because of abuse. The second time was after my brief marriage and a move out of state. I lived with my sister, with a lot of different people, wherever it was convenient.

Variability in rents. The amount of money tenants paid for apartments varied considerably. As a point of housing policy, subsidized tenants are expected to contribute 25 to 30 percent of their total income toward rent and utilities. In practice, the 50 respondents whose rent did not include heat, and who were on welfare and not working, paid between zero and \$117 a month rent (four of the 50 paid \$12 or less per month; two paid no rent). Those living in apartments in which the rent included utilities paid from \$56 to \$133 per month if they were on welfare and not working. The market rates for all the apartments ranged between \$475 and \$950 per month (excluding two out-of-state residents paying under \$300 and one living in a rooming house for \$220 per month). There is no set value for public housing units.

The average monthly tenant rents (and market rates, where appropriate) for those responding to this question (n = 77) are as follows:¹²

Apartment	Tenant Rent	Market Rate	
Subsidized with utilities	\$116	\$700	n = 20
Subsidized without utilities	\$ 74	\$651	n = 42
Public housing	\$107		n = 8
Unsubsidized without utilities	\$456		n = 4
Unsubsidized with utilities	\$507		n = 3

The frequency of monthly rents in specific dollar amounts is summarized below.

Tenant Rent	Unsubsidized (n = 7)	Subsidized (n = 64)	Public (n = 8)
\$0-\$24	0	5	0
\$25-\$49	0	16	0
\$50-\$74	0	16	3
\$75-\$99	0	11	1
\$100-\$149	0	9	3
\$150-\$299	1	6	1
\$300-600	4	1	0
\$600-800	1	0	0
\$800-999	1	0	0

School and Work status

At the time of these interviews (summer and fall of 1990), half of all respondents were either working or in school. The percentage was even higher among mothers whose children were out of diapers; three-quarters of those with children aged three and over were at work or studying.

Age of Youngest	Working, in School, or Disabled
No children (n = 2)	100%
0-2.9 years (n = 52)	40%
3-5.9 years (n = 15)	80%
6-12.9 years (n = 6)	83%
13+ years (n = 4)	50%

Having more than one child also made it more likely that a mother stayed at home.

Number of Children	Working, in School, or Disabled
0 (n = 2)	100%
1 (n = 34)	65%
2 (n = 27)	37%
3 or more (n = 16)	50%

Not all work experiences were similar, however. Because reported earnings reduce welfare benefits, food stamps, and housing subsidies (as will be explained later), nearly half (42%) of those who worked did so “under the table.”

Full-time work. Seven women had full-time jobs and earned over \$9 an hour on average. The two with the highest incomes, both nurses, earned over \$30,000 yearly. Both were proud of their work and hoped to continue their educations. Of the other full-time workers, three were in business-related fields, one was a full-time nursing assistant, and one was a housing advocate at another shelter. Their gross hourly earnings were \$9.20 per hour. This is well above poverty wages, and well above the point at which a welfare recipient is financially better off working than not working.¹³

Part-time work. Of the nine engaged in part-time taxable work, most earned between \$250 and \$450 per month (with no benefits) in retail, piecework, waitressing, or as personal care attendants. One, who earned almost \$800 a month for working twenty-five hours a week, was collecting partial benefits. Most in this group also reported liking their work, but unlike those in full-time work, did not see themselves doing it for the long term.

A married mother with four children in elementary school talked about her work this way:

My husband and I both work. I work thirteen hours a week as a nurse's aide in a nursing home. Sometimes I feel taken advantage of by the clients. I might want to get into something like physical therapy. But our family's doing okay. We budget carefully. We got a car last month. We hope to get a washing machine next. We went on my first vacation in twelve years this past summer, the first ever for my children.

A twenty-one-year-old respondent had a different work history:

I've had a lot of jobs. I used to do data entry. I worked in a pizza place for a year. I was out of work a couple of months, then I got a job in a clam factory. I can make up to \$24 per hour doing piece work. So far the most I've earned is \$250 in a week — it all depends on if they have work. I like it. It's robot work, but I have potential for making more money. As piecework, I think it's okay.

Under-the-table work. Twelve respondents mentioned working under the table, one full time. The others worked occasionally, up to twenty-five hours a week. Most declined to specify monthly earnings, noting simply that it varies. Most in this group didn't talk of loving their work, but spoke of it rather as a means to an end. Said one, “I clean a lady's house every Friday. I haven't had to go to one of those places for food [food pantry] in a long time.”

And another: “I earn \$42 a week baby-sitting, sometimes more. Baby-sitting allows me to send my child to day care. I'd really like a day care subsidy, though.”

A third had an innovative way to make ends meet: "Right now, I'm the volunteer manager for the soup kitchen in town, so I'm bartering my time for food. Another time I was the caretaker at a farm. Still, sometimes I borrow, sometimes I owe."

Education. School also played a large part in the lives of the respondents: 50 percent had enrolled in educational courses since leaving Wellspring. Eighteen percent were currently enrolled in school, and 54 percent named a specific educational goal. Many were proud of their recent academic achievements. Said one:

I only had an eighth-grade education when I stayed at Wellspring. Since then, I got my GED and started an associate's degree at North Shore [Community College]. Now, I want to transfer to a four-year college. I'm really proud of my schooling. I did very well on my GED. I want to be off welfare and be a good example for my son.

Completing all the welfare paperwork necessary to enroll in school, applying for financial aid, and finding enough money to purchase books was difficult. As one noted in a focus group:

I had to deal with so much bullshit to get approved for school. They make you think, maybe I will stay on welfare so I don't have to deal with this. Anyways, I had four classes and they made me take five classes to get full-time day care. Now they're saying if I don't take six classes, I lose my day care. With six classes, I'll probably flunk out.

Not working or in school. Fourteen percent of those surveyed had little work or school experience: they had not worked before coming to Wellspring, had not worked in the last twelve months, and had not returned to school since leaving Wellspring. These women had little understanding of the job market, appeared more isolated, and were more likely to name marriage as an important goal. As a group, they had less education and were more likely to have left an abusive situation than the rest of the group. All had children under age four; seven of eleven had children under age two. Only three women had cars.

Not working, however, did not necessarily mean dysfunction or lack of motivation. Three who had full-time work in the past year now worked under the table or not at all. Said one,

Living in poverty is hard — but on the whole, I'd rather have time with my child, stay in touch with my friends, and be able to attend AA meetings. When I was working [full time in Boston], I had no energy left for my child and I saw our relationship was deteriorating. Now I work in a neighborhood store under the table. I hate it, but it serves its purpose, and I'm starting to get to know more of my neighbors.

Daycare arrangements. Because so many respondents have preschool children, day care is a large concern. Sixty-five respondents (82%) had preschool children, and a large majority of them (75%) have or would like to have a day care subsidy.¹⁴ Specifically, 25 (38%) had a subsidy, 24 (37%) wanted one, and 16 (25%) did not want day care at all.

The one woman who worked full time under the table was paying for full-time day care out of her unreported earnings, rather than reporting them and applying for a day care subsidy.

The Welfare Experience

The respondents do not see welfare as “free money.” On the contrary, they find welfare benefits to be accompanied by high costs: costs in hardship for themselves and their children, in their sense of control over their lives and their futures, in the respect they receive from others in their communities, and in their sense of self-esteem.

Basic decisions are denied them by a system that relies on vouchers, subsidies, and allowances that are restricted in all kinds of ways. They don’t, for example, have the choice of living in a smaller apartment in order to have a more reliable car or some money in the bank. One respondent noted, “It’s just a basic lack of independence. You have no control. Everybody — housing, welfare, your parents. Everybody has you in a spot, like you have to stay there forever.”

A focus group participant articulated her painful feelings about being on welfare: “They want to crush you and grind you into the floor like a cigarette butt.”

Specifically, the issues respondents raised fell into the following areas:

- Economic: welfare benefits are inadequate for even the essentials of survival; accumulating savings or acquiring credit is virtually impossible. Policies about child support from fathers are unfair.
- Attitudinal: welfare benefits are accompanied by stigma: active discrimination and the loss of both respect and self-esteem are frequent.
- Disincentives to independence: rather than offering incentives to get off welfare, welfare policies effectively punish those who work the hardest to become independent.
- Welfare policies and workers are controlling, restrictive, intrusive, and confusing.

Economic issues. When asked what they considered to be the hardest thing about being on welfare, 65 percent of respondents said it was not having enough money. They have reason to complain: the federal poverty line¹⁵ for a family of four is \$10,609, but in Massachusetts that same family receives 30 percent less: \$7,536 (\$628 per month) in welfare cash benefits.¹⁶

AFDC recipients have incomes well below the poverty line, and their incomes have not kept pace with inflation. The problems of supporting a family on such meager allowances were amply demonstrated by the respondents. Said one woman, “It’s not enough for clothes and bedding. I run out of food one week early. My children get diarrhea because all they eat is macaroni and cheese. There’s not enough for meat.”

Another added, “Once in a while, it’s gotta be Christmas. Everybody tells you to budget, budget, but they have money.”

To make ends meet, 60 percent of all respondents borrowed from boyfriends or relatives; 40 percent used food pantries or similar free food services. Figures were even higher among nonworking mothers on welfare: 87 percent borrowed or used food banks; only 13 percent reported not having to do either.

But asked how they managed to get by, all had strategies for survival on such limited means. Some were desperate, some inventive:

“I always run out of money. I call my dad up crying.”

“A volunteer brings me food vouchers from Saint Mary’s [a local food pantry]. My girlfriend gave me a microwave. My sister gives me hand-me-downs.”

"I use coupons, budget. I just got a perm, but that's unusual. I just have to let things go sometimes."

"I have a vegetable garden with my sister. We freeze vegetables for the winter."

"I stock up on diapers and canned food."

"My neighbor and I share dinners the last week of the month. The only time I went to a food pantry — Catholic Charities — was when somebody stole my check."

"I just do without."

The economic situations of the respondents were not appreciably improved when the fathers of their children paid child support, as 43 percent did. A few of these (7 percent of the total) paid money directly to the mothers of their children; 36 percent of the fathers had money deducted from their paychecks directly to welfare. However, regardless of the amount paid by the fathers, which ranged from less than \$100 to more than \$300 per month, the children's mothers received only a \$50 increase in benefits. Respondents argued that all child support money paid by their children's fathers should come directly to them. Said one:

My children have two different fathers. Together they pay \$800 a month, but I only get \$579 total. Where does that money go? [But] if they just paid me [instead of the welfare department], some months I'd get nothing from one of them. I can't go back to the rent not being paid.

Difficult as their situation is, respondents spoke also of their fear of things getting even worse. They spoke of living "check to check," of surviving "by the skin of my teeth," and of fearing every possible budget cut because it would take away what little they have. They spoke of possible state cutbacks as barriers to their dreams, mentioning especially their fears of freezes in benefit levels and loss of day care subsidies, fuel assistance, and WIC.¹⁷

Respondents complained that both immediate and long-term needs are affected by being on welfare. With its stringent limitations on possession of assets,¹⁸ welfare makes it virtually impossible for recipients to save money or get credit. One said she was refused a bank loan; another couldn't insure her car. Said another, "I can't put money in the bank. Welfare took away my life insurance. Guess who's got to bury me when I die? They took away my son's trust fund."

Attitudinal issues. Collecting welfare has negative connotations for most people, and respondents were sharply aware both of how others felt about them and of how they felt about themselves as a result. Said one in a focus group, "Everybody in the working class looks down on everyone in the welfare class. You notice it wherever you go."

Respondents spoke of hearing slurs like "on the dole," "lazy welfare mother," and "Section 8 deadbeat." Many told stories of strangers accosting them in stores for using food stamps. One respondent told of trying to refute stereotypical statements made by fellow college students about welfare mothers and the homeless. Another noted that a coworker asked her why "you welfare people have enough money for shoes but not for fuel." Still others spoke of encountering hostility from workers at housing and welfare offices. One said her worker told her "to go out and pitch a tent."

Said another, "My welfare worker was hostile. She didn't tell me about stuff or told me I wasn't eligible."

They felt conspicuous and despised.

It seems like here in Gloucester everybody knows [you're on welfare]. If someone asks you what do you do, it's like, "O-o-o-o-o-h-h-h." They think all kinds of things. You get discriminated against.

The worst thing is the way you are treated. I want the respect I deserve. Not everyone on welfare is a bum or wants the government to support their drug and alcohol habits.

Nevertheless, some respondents were able to achieve a sense of pride from being able to survive such difficult times. Said one, "I get by. If my house is full of food, then I'm happy. If I can't get my kids what they need, Similac [infant formula], baby food, then it's really hard."

And others:

I like my life. I'm going to school full time. I just buy the necessities. I'll wear a sweater and keep the heat down . . . I'm happy. I can pay bills and buy cigarettes. I've been down before but I know I'm not going to be on welfare for the rest of my life.

I hate welfare. I'm going to be off, though. I'm taking my GED tomorrow and then I can go to college or get a job.

But inevitably, some internalized the negative attitudes that surrounded them. Four, for example, reported feeling guilty and uncomfortable about having to rely on the government for support. One said it "made her feel crappy just being on [welfare]."

Said others:

It's like I'm never going to get anywhere — I'm going to be on welfare for the rest of my life. I can't go out and work with a baby so young. I got a certificate in word processing a year ago, but it's been too long. I can't get hired now. It seems hopeless.

There's nothing to look forward to. Welfare and disability doesn't go far.

I can't read and I can't spell. By the time I get to there [college], the Pell grants, the rest, it'll be gone.

Others directed their anger at people they perceived to be playing the system. Said one: "I know one girl who's trying to get pregnant again because welfare is telling her to join ET."¹⁹

Added another who had been working for some time: "I think welfare benefits are too high. People should be out working."

And another: "People should be grateful and not abuse the system. People shouldn't be allowed to stay on welfare. I'd limit it to when your youngest child is five, unless you are disabled, or your child is sick, or something."

Issues of incentive. When those now off welfare were asked about the hardest aspect of being welfare recipients, two-thirds mentioned first neither lack of money nor stigma, but rather the difficulty in finding a way to get off welfare. One of the most frequent complaints was that while recipients knew that earning income would affect their benefits in some way, it was virtually impossible to find out in advance what the effect of any particular action would be. Respondents told story after story of being thwarted, discouraged, or punished in their attempts to make a better life for themselves.

Every time you get something like financial aid from school, or any kind of a job, your rent gets raised and your food stamps get lowered.

They took my food stamps away when I had my second child. They lied to me. This happened because I asked ahead [about what would happen if the child's

father lived with us], and I told the truth. Now my youngest doesn't have Medicaid. I hate it.

Welfare — they say they want you to get on with your life, but they don't give you the chance to get ahead. They say do this, do that, work, school. If you do work, they cut you right off.

I wanted to offer my friend affordable day care so she could work, but welfare would have taken everything away.

These respondents were aware that working or going back to school would affect their benefits in some way, but they reported that welfare workers did not help them count the costs: "I've been trying to work since summer. They won't tell you ahead of time what you might get. They don't give you enough incentive to get off welfare."

The lack of accurate information about the real costs of returning to work or going to school becomes a major barrier to moving ahead. So, too, does the fear of losing some of welfare's major benefits, like Medicaid: "I told them I have to keep my Medicaid when I go back to work. I argued. I said I'd write to the newspaper about how they were preventing me from going to work."

In fact, while recipients reported being told that they would feel better about themselves by taking any job at any wage, they were more likely to face feelings of anxiety than increased self-esteem. Welfare allowed them no savings or assets to cushion any problems, yet if they went off welfare to accept a job that didn't work out, it could take them three weeks to get benefits again. "That," said one respondent, "is why girls don't want to work. If you're on welfare, you know you're going to get a check. Who knows everything that can happen if you have a job? If you have a job, you can't quit, you can't take that chance."

Another who reluctantly found more security in welfare than in work said poignantly, "I feel like I could be homeless again if I went to work."

How working affects income. Along with fear and lack of information is the reality that working does welfare recipients little if any financial good. Although the system is complicated, for the first four months of work recipients basically keep one third of their earnings over and above their welfare benefits. Thereafter, with some exceptions (small allowances for transportation and child care, for example), every dollar earned essentially results in a dollar less in benefits. Welfare and other benefits are cut (food stamp allotments and rent subsidies decrease and public housing rents increase, for example) according to a federal formula.

Three examples show how working affects gross income.

Case 1: Former guest earns \$325 per month and has one child

Not working: AFDC + Food Stamps = \$557; Rent = \$48

Postrent Disposable Income: \$509

Working: Earnings = \$325; AFDC + Food stamps = \$327; Rent = \$56

Postrent Disposable Income: \$596

Differential: \$ 87

In a job paying a minimum wage or slightly better, this woman could work nearly one hundred hours a month and end up with an effective pay rate of less than \$1.00

per hour. If her child needed day care, those expenses would also likely reduce her take-home pay: reimbursements for child care expenses are only \$1.00 per hour, far below market rates, and only for the first twelve months of working.

Case 2: Former guest earns \$795 per month, and has two children

Not working: AFDC + Food stamps = \$730; Rent = \$107

Postrent Disposable Income: \$623

Working: Earnings = \$795; AFDC + Food stamps = \$100; Rent = \$132

Postrent Disposable Income: \$763

Differential: \$140

Assuming a higher rate of pay rather than simply more hours, this woman seems to be somewhat better off than her Case 1 sister. However, taxes complicate the picture. Both women would have withholding and Social Security taxes taken out of their gross earnings. Even though they would likely get at least their federal taxes back — and perhaps more through the earned-income tax credit — it would be a year later. Social Security taxes, of course, would not be refunded.

Case 3: Former guest earns \$1,300 per month, and has two children

Not working, same as above example,

Postrent Disposable Income: \$ 623

Working: Earnings = \$1,300; AFDC + Food stamps = 0; Rent = \$257

Postrent Disposable Income: \$1,043

Differential: \$ 420

Even with a fairly large differential between working and welfare incomes, this woman may be little if any better off. At this income level she would lose Medicaid after twelve months, and so would either have to pay for health insurance (even company policies reduce take-home pay) or for health care as needed (a considerable expense for families with small children) and risk financial disaster if serious illness struck her family. And as always, increased income means increased taxes, reducing her disposable income even more.

Despite such large economic disincentives to work, those surveyed not only wanted to work, but many were working. It is probable, though, that the steep reduction in benefits for taxable earnings increases the likelihood of working in the underground economy.

Community involvement. In general, respondents had strong connections to their communities. Fully 80 percent, for example, reported knowing their neighbors on better than nodding terms. Many formed friendships with neighbors, even when they lived in their apartments for fairly short periods of time. They mentioned cookouts, sharing baby-sitting, or simply spending time together as ways they interacted with neighbors. A few said they did not like their neighbors, either because their children were too rough or because they believed the adults to be drug dealers or prostitutes.

Half the respondents reported participating in some community organization or activity, such as volunteering at their child's school, attending church or Alcoholics Anonymous (AA) meetings, bowling on a team, participating in a political organization, or regular attendance at a weekly activity such as Beano. One woman who gained a sense of self-esteem through volunteering noted:

First I volunteered at Head Start. Then I got hired as an aide, then as an assistant teacher. I enrolled in teacher training, but the state canceled [it] . . . I still volunteer at Head Start, even though my child's in school now . . . When they finish building their community center, I want to get involved there too . . . I plan on taking courses in Spanish and child development when I go back to school.

In addition to Wellspring, several agencies or community groups were found to be particularly helpful to them. AA has made an impact in the lives of many. Said one, "When I came to Wellspring, I felt powerless and didn't know anything. Now, with AA and trust in a higher power, I feel terrific. I'm proud of staying sober and enjoy helping others who want help."

Community issues and political involvement. Connection with one's community involves more than one's individual activities; it extends to perceptions about and actions concerned with the larger, often political, issues in the community. Here, too, many respondents were aware of salient community issues and involved in political action.

For example, when asked about the biggest issues in their community, 35 percent of those surveyed named drugs. This was triple the number of times cited for any other single issue, such as crime, homelessness, the economy, or state budget cuts. (When asked specifically whether there was a crime problem in their neighborhood, however, 28 percent said there was.)

When asked for opinions of their neighborhoods or cities, the presence of drugs was usually the reason for dislike. The problem figured especially large in Gloucester, a port of entry for heroin and a city with one of the highest per capita addiction rates in the state: of the sixteen people who indicated strong dislike of the city they were living in, thirteen lived in Gloucester. Stated one, "I don't like Gloucester . . . There's too many druggies and alcoholics. The drug dealer finally moved out of the upstairs apartment."

Our respondents were only slightly less likely to vote than the general public: 43 percent were registered to vote. Several others answered, "That's something I gotta do," when asked if they were registered. Those over twenty-five years old were 1.5 times more likely to vote than those under twenty-five.

Many, however, seemed isolated from political processes. Those in power were frequently referred to as "they" or "them," as in this comment:

They can put a billion dollars into rocket ships and to clean out the harbor — but money into housing, to shelters for the homeless, is more important. The harbor's been dirty for centuries. They think it's more important to keep capitalism. They keep taking from the poor. It's true the rich are getting richer and the poor are getting poorer. They keep taking from the poor. All those new cuts? They're scaring people so they can raise taxes. They are raising their salaries, but they're taking day care [away from us]. There's nothing to do. It's going to get worse."

Others spoke of the futility of political action:

I went to the State House when I lived here. They didn't care what we said. I didn't change anything. They won't listen to the little people. They never will.

These days people don't want to hear about poor people, welfare, sickness, any of that. They just want to stay away.

There were, of course, those who found political action fulfilling:

I'm involved in Citizens for Sober Alternatives [antidrug community group]. We've done fund-raisers. Now we have a social center for kids. We're working . . . on proposals . . . We're trying to talk at high schools. If the group has a goal, [it is] community awareness. These are addicts, they are people who will pull together to help. I designed a T-shirt for them for free. It's something I can do.

Hopes and dreams. Two of the major questions Wellspring hoped this research would be able to answer were What are the hopes and dreams of people after they leave Wellspring? and Do they feel they can achieve their dreams? Asked for their own goals, and for a glimpse of their futures in three to five years, the respondents gave us mixed results. Many maintained — or reclaimed — the same kinds of hopes and dreams as one would expect to find among mothers untouched by homelessness. They wanted careers, their own homes, financial security, marriage, good relationships with spouses and children, and the ability to pass something on to their children. Most respondents were able to make reasonable plans for achieving career goals, but owning their own homes seemed a receding dream.

A few, however, were simply too scarred by their pasts to look into the future with hope. The shattering combination of homelessness and bitter life experience made dreaming difficult for some, quite literally unimaginable for others. Asked in focus groups to "close your eyes and really dream," participants gave some especially poignant responses. "Dreams?" scoffed one. "Let me grow up first. I'm going through my first childhood. I'm still waiting to know what I want. I started using drugs when I was twelve or thirteen, so now my son can help me grow up."

And others: "If I dream, I dream of being an ice skater. I wish I didn't have M.S. [multiple sclerosis]." "I just want to be sober. I can't . . . I really can't think or go beyond that."

Another, who thought first not of her own dream but of her partner's, was unable to disentangle them:

His dream is to move to New Hampshire, and I'm going to go along with it . . . Oh, my dream? It's typing. It will take a while, but I can do it anywhere. I couldn't do it without him, though. I want to get myself stable. He wants his own business. We'll see what happens.

Still another began trimming her dream almost as soon as she spoke: "I want to be totally off welfare, my kids in private schools . . . Well, off welfare for sure, and in my own home if that's possible."

Careers and education. Among the dreams noted in interviews, careers and education figured high: 87 percent named a job or career goal and 54 percent aimed toward specific educational goals. Fully two thirds of those with career goals could name a specific type of full-time job they wanted; the other third either wanted part-

time work or indicated they would take any job they could find. The listing below shows the career goals for those who named a specific field.

Job	Frequency	Job	Frequency
Teacher	2	Own business	2
Day care provider	2	Business/computers	7
Doctor	1	Legal/paralegal	4
Nurse	4	Artist/musician	5
Nursing assistant	3	Food science/cook	2
Other health work	3	Hairdressing	2
Psychiatrist	1	Human services	5
Veterinarian	1		
Farming	1		
Forestry	1		

Perhaps because of the many artists already resident in Cape Ann, quite a few of these former guests dream of becoming self-employed artists. The desire to be self-employed is shared by more than would-be artists, however. Whether they mentioned farming, day care, business, or hairdressing, more than a few of these women longed for control at their place of work. For example: "I don't know what I want. Well, I do, but I'm scared I'm going to be poor forever. I don't want to be bossed around by some decrepit boss who's going to make my life miserable."

In education, goals included learning to read, getting a GED, getting a B.A. One respondent, a nurse, even spoke of going to medical school. Said another: "I want to get an education in business. I don't want to go out and get any job just to get by. I have an appointment at welfare to discuss options. I don't want the welfare work program, though. I want to go to college."

Some were progressing purposefully along their chosen path. Said one,

I want to be an art teacher. I'm taking an at-home correspondence course. I have a portfolio together. I have some odd jobs. I'll be taking courses at Montserrat [College of Art]. But dreaming? I'd love to be rich and sit in my studio looking out over the water and paint.

Others were a bit more unrealistic about their goals: the woman who wanted to be a veterinarian had only her GED and was recently sober. Some were perhaps confused about the steps involved:

A year or two from now I'll go for my GED and high school diploma. The kind of job I really want is producing and choreographing music. I want to own my own record company. Maybe I'll take a radio station job or something at first.

Home ownership. For twenty-one respondents, buying a home was a major goal. One who hoped to become a forester wanted to build her own house. Others wanted to own a trailer or a "cabin in the woods," a condo or co-op apartment, a single-family house, or a house through Wellspring Land Trust. Many, however, expressed anger at a system which they perceive to be making it harder and harder to achieve this American dream.

I want a house through Wellspring Land Trust. I'd rather be paying for something to belong to us. Now it's impossible to own a house. If housing were tons more affordable . . . like in Russia they give a couple a house. Now, I'm not a communist, but why is [it] that here only the upper crust can afford a house?

I want to own my own home. The most expensive thing I own is a \$300 TV. It just seems so long until I own anything or have money in the bank.

Families. Family concerns were important for these women as well: they dreamed and hoped for good or improving relationships with partners and children. Twenty-two named marriage as one of their hopes; fifteen spoke of wanting to continue to develop positive relationships with their children, boyfriends, or husbands. Said one,

I hope things get better. I'm having trouble now. One kid is hyper and needs counseling. The little one is partially deaf. My ex-husband — he's so irresponsible. My children love their father, but he screws up. He won't keep to certain foods — they're on special diets — and he won't change diapers. I still suffer when he lets the kids down.

Like mothers everywhere, these respondents dreamed for their children. Asked for their greatest hopes for their children, they said they wanted them to be happy, healthy, responsible, smart, straight, self-confident. They wanted them to go to college, to work at good jobs. But some hopes reflected already bitter experience: they hoped that their children would recover from sexual abuse already suffered, that they would never be homeless again.

Asked for their greatest fears for their children, these mothers named drugs more than three times as often as anything else. This list of things they fear for their children reflects the scars of their own lives.

Fears	Times mentioned
Drugs	34
In with the wrong crowd	10
Violence: kidnap, abuse, murder	9
Rape, sex too early, AIDS	7
War	6
Separation from me	5
Repeating my mistakes	4
Becoming homeless	4

Other dreams. Thirteen respondents named financial goals, including having more money, paying off debts, saving, and becoming self-supporting and secure. Others spoke simply of hoping to be happy, to keep growing, to become better people.

Larger dreams had their place, too: some spoke of wanting a better world, free of war, drugs, or AIDS, or of a country with a completely new political structure.

Pride and accomplishment. Like women everywhere, these respondents had, when asked, varying sources of pride and feelings of accomplishment. Just over half named their children or their own sense of competence as mothers as their greatest accomplishment. Said one, "I'm proud of my new baby. She's so smart and goofy. Nobody

else but me helped raise her — not my mother, my brother, foster care, no one. This baby's my own and I'm proud."

Thirty percent (more among those under twenty-five) said they were proud of their independence and their ability to make it on their own. For example, "My greatest accomplishment is not quitting or giving up. I am a survivor and I know that I can do anything I want to."

Four of the seven women employed full time named their employment as the thing they are most proud of, while one third of those who had taken courses or gone to college since leaving Wellspring included schooling among their accomplishments.

On Preventing Homelessness

These women who have suffered through the experience of homelessness had many ideas to offer about preventing it. They included creating more affordable housing, creating higher-paying jobs, and funding long-term programs to reduce drug abuse, teenage pregnancy, domestic violence.

A resounding majority felt homelessness was caused in great measure by the high cost of renting an apartment. With rents on the North Shore seldom lower than \$550 to \$600 a month, women with minimal education, small children, and chaotic life situations are ill equipped to pay such rents when they leave whatever housing situation they have been in. But there were minority views. One respondent said the reason for homelessness was that people "didn't apply for housing soon enough." Others pointed out that there are those who are taking advantage, that preventing fraud would eliminate some of the alleged homelessness.

Alcoholism in their families, or drug abuse by their partners or themselves, was frequently cited as a contributing cause of homelessness. Many respondents indicated that a fundamental cause of homelessness was family breakdown, and that a major factor in family breakdown was drug or alcohol abuse. Many told interviewers that they had become homeless when their parents had thrown them out of the home, often because they were pregnant. Said one,

How many women know enough to put a condom on that thing? I took the pill . . . when I remembered. I had no idea what AIDS was. I sorta knew I was going to get pregnant. My mother wasn't able to talk to me about that stuff. Now we laugh about it, she and I. But maybe she wouldn't have been such a young grandmother.

Abusive relationships also took their toll on the respondents: as already noted, abuse was the single most frequent contributing factor. Some of those who spoke of abusive or nonsupportive relationships with men felt it was their own fault for getting involved with an abusive man. As one said, "Women could become a lot smarter in getting out of relationships."

Others did not feel they could have changed the situation.

To say you have to leave and end up with nothing and go to a shelter, that's hard. Maybe months before you could have recognized the situation and searched for ways to get out of it, get help sooner. But you're never aware that your life is going that way until you're in a crisis. You've got to be responsible and ask — Is this normal?

Respondents had many ideas about both creating more affordable housing and preventing homelessness. Several proposed easier access to a pool of emergency housing

certificates, shorter waiting lists for units in public housing, or simply "cheaper rents." A few suggested changing the system so that one could receive a housing subsidy without ever having to become homeless. Others recommended rehabilitating old buildings into affordable rental units, rather than into "condos for the rich," or using public land, such as that bordering on highways, to build housing for low-income people. One wanted government support of trailer parks so that those of modest means could own their homes. A few specifically mentioned rent control. Others thought the land trust was a good next step in preventing homelessness. To some, more shelters, more Well-springs, would be an important factor in reducing homelessness.

Others focused on the income side of the equation, on the need for higher wages, more jobs, a better economy, or higher benefit levels to those receiving public assistance. Some talked about the need for preventive measures when someone is in danger of becoming homeless. One said that if she had known she had other options besides going through an entire eviction proceeding, she would not have become homeless. Others indicated that they would not have become homeless if affordable day care had been available to them when they were working. Several asked for community centers to provide counseling about tenant skills, budgeting, and knowing one's rights as a tenant and as a woman being abused.

A third of the respondents mentioned the need for such long-term prevention strategies as improving schools, increasing the self-esteem of teenagers, reducing drug and alcohol abuse, providing more sex education and birth control, more job training, more education about relationships, and more drug and alcohol treatment centers.

Some respondents, noting that they themselves felt guilty about not finishing high school, suggested that schools be more responsive to the individual needs of students, and perhaps offer more work experience options. They said schools should also stress to those considering dropping out the importance of a high school diploma in getting a job.

Many mentioned the need for more sex education to prevent homelessness. Some stated that they had had at least one abortion because they didn't know how to prevent unwanted pregnancy when they were teenagers. But more said they weren't aware of the full consequences of parenthood when they became sexually active.

Several spoke of the need to educate the public about homelessness. One noted,

There needs to be more understanding on a personal level about homelessness. Get as many people involved in dealing with homelessness — community, businesses, schools. The state has to do more, not less. The public has to be educated — who are the homeless, what homelessness is.

Some respondents specifically mentioned that the United States spends too much in other countries. Only one mentioned too much money being spent on defense. The others felt that more federal money should be spent on those who are poor, hungry, or homeless in this country before giving economic aid to other countries.

Like any group of Americans, the respondents had views that were not homogeneous. Some ideas were radical ("They should give free housing"), progressive ("They have to give more money to people, not to wars"), liberal ("Job training, education about women's rights"), conservative ("People just have to appreciate themselves more so they don't get into uncontrollable situations"), and reactionary ("People who come to this country shouldn't expect everything should be given to them").

Many people gave long and thoughtful answers to this question, crossing the boundaries of political labels. For example:

There needs to be more affordable housing, more drug treatment, and more education about drugs. There are creative ways to develop affordable housing, especially ownership like co-op apartments, saving trailer parks. Get people invested in where they live. Change people's stereotypes about who the poor are — educate, organize.

An eighteen-year-old high school dropout added,

Prevent homelessness by stopping the abuse, by teaching people another way. Teach people to balance their budgets, teach your own kids not to abuse anyone. There could be programs in the community around issues, issues like self-esteem, drugs, and abuse. That could help.

This study is, of course, only the beginning of what should be a process of discovering what homeless people really need to secure and maintain both their homes and their lives. There is need for much more research in this area; certainly Wellspring's guests do not reflect the totality of the homeless population, and caution must be exercised when attempting to generalize any of these findings.

Nevertheless, this study does mark a beginning. It shows clearly that a large proportion of homeless mothers become so because of the unfortunate confluence of economic change, family breakdown, and the high cost of housing. It shows that for the overwhelming majority, the provision of affordable housing enabled them to reclaim both reasonably stable lives and the same hopes and dreams shared by others more fortunate. And it shows that many of them see as clearly as any social scientist the forces at work in their lives and their society.

This study shows not dysfunctional women, but rather mothers who have managed survival despite tremendous odds, and who often flourish in a more stable and nurturing environment. Given that environment, their ability to function seems most often to take care of itself. In other words, let them have housing and they will not be homeless. 🐼

Notes

1. Michael B. Katz, *The Undeserving Poor* (New York: Pantheon Books, 1989), 7.
2. Ibid.
3. Michael Harrington, *The New American Poverty* (New York: Penguin Books, 1984), 230–31.
4. Information about the Wellspring survey is adapted from its report, "We Are Like You: The Lives and Hopes of 79 Formerly Homeless Women," research by Helen Hemminger, text by Wendy Quinones, in *Choosing the Future: Proceedings* (Gloucester, Mass.: Wellspring House, 1991): xx–xx.
5. People may become eligible for housing assistance on a priority basis if they have become homeless because of, in levels of descending priority, (1) public action; (2) natural causes; (3) abuse, substandard conditions, eviction, health and safety concerns, a medical condition, and so on.
6. Katz, *Undeserving Poor*, 7.
7. Rosemary Haughton, "Introduction," *Choosing the Future*, x.

8. GED is the General Equivalency Degree, a test high school dropouts can take in lieu of completing high school courses to show proficiency at the high school level in a variety of subjects.
9. Mothers with children who receive welfare benefits are usually on an assistance program called Aid to Families with Dependent Children (AFDC). Individuals with no children in the home may be eligible to receive Supplemental Security Income (SSI) if they are disabled physically or mentally. Others may be eligible for General Relief (GR), which is a cash assistance program for individuals.
10. "Eviction" referred to either legal eviction by a landlord or being asked to leave an apartment rented or owned by a friend or family member. "Separation" referred to separation from a boyfriend or husband in which physical abuse was not specifically mentioned. "Pregnancy" was the reason for homelessness if her pregnancy was the cause of her being asked to leave the place she was living, or she was not able to keep her job, or if she chose to leave because she was living in an unhealthy situation for a pregnant woman, for instance, with drug abusers. "Overcrowding" referred to living in a situation with more than twice the number of people as bedrooms, and usually implied, "We weren't getting along."
11. Some of these public housing units are in small apartment buildings and others are in complexes of low-income housing projects administered by the local housing authority.
12. Unsubsidized tenants appear not to have paid the market rate because one in each category was living with a roommate and each paid half the rent.
13. Focus group participants mentioned \$7 or \$7.50 an hour as making it worthwhile to be off welfare. When computed arithmetically, it appears one would need at least \$6.20 an hour to match the value of various benefits dollar for dollar. This computation ignores several contingencies, however: an individual might need more money to offset the increase in rent because of her earnings, while another might need less because once off welfare she could collect the full amount of child support paid by her children's father(s).
14. Subsidized day care means either welfare or the Department of Social Services pays for day care either to an approved family day care provider, or in a formal day care center. Head Start and Early Intervention are not included as day care centers, since their aim is primarily educational and because they do not offer all-day care.
15. The definition of the federal "poverty line" and its application to real-life situations is a controversial subject. In theory, it reflects the minimum necessary to meet the basic needs of food, housing, and transportation, but many dispute its usefulness. Some states have abandoned it altogether in favor of other measurements of poverty.
16. Food stamps, rent subsidies, and Medicaid may also increase the value of benefits. The value of these benefits is a much-debated topic, but they are not paid in cash and are useful only when and if they are used. If a child is sick, for example, Medicaid's cash value is the cost of the illness; but what is the value of Medicaid when the child is healthy? Because these benefits are so difficult to quantify, we have chosen not to look closely at them.
17. WIC is the acronym for Women, Infants, and Children, a federal program providing pregnant women and children under five with coupons for food items such as milk, cereal, and juice.
18. Welfare recipients may have no more than \$999 in the bank and a car valued at less than \$1,000.
19. ET is Massachusetts's much-heralded — but now terminated — program designed to help welfare recipients return to work or to school. Although registration is mandatory, participation is not. Those who participate choose between work, school, and job-hunting assistance options. Day care is provided while women actively participate in the program.

Winter

Edward Baros

Snow lifts it by slowing the movement
expected, makes walking slower, harder,
makes face ache, eyes blur, hands fumble,
makes the day explicit, the night quiet,
the outside more so and the inside glow
with warmth, with people if you're
lucky, if the world's good to you, won't
simply kill you, freeze you.

9/22/91

The Grassroots Home

How Local Communities Are Fighting Homelessness

Sheila Rauch Kennedy

In the 1980s federal policy combined with market forces to produce the American tragedy of homelessness. Since that time influential policymakers have debated every aspect of the issue, but avoided the large-scale commitment needed for solutions. Locally, however, grassroots efforts have made these commitments and forged the coalitions needed to address the issue. The solution to homelessness lies in harnessing these same successful public and private resources on the regional and national levels.

It was a few nights before Christmas 1991, but few were jolly; no one in New England needed to be reminded that times were tough. Many who had never dreamed of being unemployed had lost their jobs. Retailers were nervous about moving their merchandise, even with preholiday markdowns. And those for whom Christmas traditionally meant ensuring that others in need were not forgotten were particularly worried.

Indeed, the public safety net so often alluded to by politicians was full of holes. Many charitable organizations whose past work had largely been advocacy and finding long-term solutions to pressing social issues were trying desperately just to meet the emergency needs of their constituents.

Each year, Boston's Emergency Shelter Commission, with the help of various city departments and volunteers, conducts an annual census of Boston's homeless. Because this census defines "homeless" as those without a "permanent" place to live and attempts to count persons living in various types of transitional housing as well as emergency shelters, many experts on the homeless consider Boston's survey to be one of the best indicators of both the extent of homelessness and trends within this population. Not surprisingly, the 1990 census takers found that both the numbers and the kind of person who is homeless had changed.

Ann Maguire, who heads Boston's Emergency Shelter Commission, the agency that provides beds for the city's homeless, shared her observations: "Like most cities, Boston still has a larger number of the single homeless. The suburbs tend to attract families, but this year we saw more working poor. We even had a former Pan

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Am pilot. While I'm glad to say there were no children on the street, there were more in the shelters for battered women, a trend which may indicate that the stress in more people's lives has reached the breaking point. And while we've seen a growing number of homeless women with children for some time, there are now a few intact families, meaning those with both a father and a mother. But again the suburbs see more of this."

Perhaps no public policy issue becomes more apparent or tragic during the holidays than homelessness. Since homelessness emerged as a national issue in the 1980s, it reappears on the public stage each year around Thanksgiving, as predictably as cranberry sauce. Only the most impenetrable of Scrooges remains unmoved between Thanksgiving and Christmas. The appeals remind us that Jesus himself was a homeless child and ask us to give generously. In 1991 as never before, the public responded.

This was the fifth year WCVB-TV, Channel 5, had held its holiday season telethon for the homeless. The show's producer, Chris Ziegler, was worried. In 1990 the station was able to raise only \$80,000, and this year the economy was worse. Ziegler and others wondered if the funds would be worth the effort. But rather than cancel the show, the station decided to stress the theme that homelessness is solvable.

While script writers stressed the need for housing as the long-term solution to homelessness, the requests for aid underscored the need for short-term assistance. The screen listed contributions ranging from computers, to books, to razors, to toys that area shelters needed. Although a \$50,000 contribution from a recent lottery winner pushed pledges over the \$200,000 mark, Ziegler stressed that most gifts were in the five- to ten-dollar range.

Ziegler also noted that while some of the positive response may have been due to the realization that in today's economy many feel "I, too, could soon become homeless," she stressed that "people wanted to feel that they were contributing to a solution; by our giving them something concrete to respond to, even in the short term, they did respond."

Channel 5 is no rookie in producing programs on the homeless. In March 1987 the station aired *God Bless the Child*, an ABC drama depicting the life of homeless children. While the station had anticipated calls and placed ten volunteers on the phones, they were not prepared for the 600 responses they received from viewers who wanted to help. "The movie touched a nerve," producer Judy Foy explained, "Our perspective changed after the show. We had to focus more carefully on the possible solutions to the problem, namely, affordable housing."

From June 1987 through December 1988, the station promoted local initiatives that provided affordable housing and produced nine prime-time specials on homelessness. The station's crews, and particularly Foy, grappled with the issue of short-term assistance versus long-term solutions to the problem. This experience and the fact that television reaches so many people gave the network a unique perspective on the public's perception of the issue.

Focusing on the long-term solutions to homelessness is the central challenge for those working to help the general public better understand why people are homeless as well as those developing policies to eradicate it. Channel 5 has found it far easier to bring people together to address the short-term emergency problems associated with homelessness than to build the long-term partnerships necessary to find solu-

tions. Without maintaining a cohesive and broad coalition, the resources necessary to solve the problem are seldom concentrated on it. For just as predictably as homelessness becomes part of the nation's social consciousness around Thanksgiving, the issue begins to disappear after the holidays and is all but gone by the time spring melts the winter snow.

Of course, while the issue of homelessness may fade from the national consciousness each spring, its reality remains for far too many Americans. And just as the cyclical nature of homelessness is a misconception, so too is the perception that homelessness is a problem our country has always lived with. True, while there has always been a small number of Americans who preferred the "freedom of the street" or the "life of a hobo" to a traditional home, homelessness did not become a national problem until the 1980s. To understand it and forge programs and policies to solve it, it is necessary to look at what happened during this period. Not too surprisingly, experts disagree on almost every aspect of homelessness, from its definition to the relevant time frame to the data to the causes, and the implications for public policy.

Problem Setting: Different Frames of Meaning

To some experts, homelessness has always been primarily a housing problem caused by the lack of affordable units. For Sue Marsh, director of the Massachusetts Coalition for the Homeless, "Homelessness is, above all else, a housing problem. We're not saying that some homeless families don't have other problems too. Let's face it — we are not a problem-free society. Yes, some of the homeless abuse drugs and alcohol, but so do many other Americans. Yes, there is physical abuse among the homeless, but like it or not, wife and child abuse also occur in very well-housed families. What makes homeless families so different from the rest of us is not that they have problems. Most of us have problems. It's just a lot harder to cope with your problems when you have no home."¹

Most homeless experts, who stress housing as its primary cause, are referred to as housing advocates. Their professional backgrounds however are more than likely to be in the social service field than one associated with housing. Those sharing this perspective most often define homelessness as those without "permanent" housing. Permanent, however, does not mean "everlasting" but refers to what is generally considered a traditional home such as an apartment or a house where the occupant intends to stay for more than a transitory period.

This definition is shared by Boston's Emergency Shelter Commission, which counts residents in various transitional units, including hotels and motels, along with residents of shelters and people found on the street as homeless. Those on the street, the only group a lay person might consider to be homeless, particularly on a cold night when the surveys are usually taken, represent the smallest segment of what many housing advocates include in this population.

Most housing advocates mark the 1980s as the decade when homelessness emerged as a major issue, and they cite the 70 percent cut (from \$33 to \$9 billion since 1980) in federal housing subsidies to those of low and moderate income as its primary cause. This group is also clear on the solution to homelessness. While these advocates feel strongly that there is a need to increase social programs to assist low-income people who are likely to experience homelessness, they are steadfast in

their view that a full-fledged federal housing commitment is the only way to solve the problem.

The U.S. Conference of Mayors is another respected source of information on homelessness. Its 1991 report on hunger and homelessness uses data from officials in twenty-eight selected cities to ascertain local views on homeless issues and measure trends in the homeless population. The figures used rely on requests for emergency shelter and the numbers of persons residing in either shelters or transitional housing. The mayors' survey found that local officials view lack of affordable housing as the leading cause of homelessness. It also found that average requests for shelter assistance had increased by 13 percent and requests by homeless families by 17 percent. The average composition of cities' homeless population was 50 percent single men, 35 percent families with children, 12 percent single women, and 3 percent unaccompanied young people. Children comprised 24 percent of the surveyed homeless.²

Other experts, however, view homelessness as the end result of social and personal crises affecting certain population groups. The Interagency Council on the Homeless, the federal organization set up to coordinate programs for the homeless, lists loss of employment, alcohol or drug abuse, domestic violence and drug abuse, and deinstitutionalizing of mental patients as the major causes of homelessness. Chaired by Department of Housing and Urban Development secretary Jack Kemp, the agency makes only passing reference to the decline in low-income housing units, a decline it sees mainly as the result of the demolition of "hundreds of thousands of cheap hotel units" in private rooming houses.³

In fact, by noting the number of units receiving federal assistance between 1979 and 1983 — a time when previously approved projects were coming on line — rather than new dollars allocated to housing, the Interagency Council implies that the federal government has been playing an increasingly larger role in housing low-income Americans. That claim is disputed by the housing advocates.

The council tallies the homeless as people living in shelters or on the street. Its data are based on a 1987 Urban Institute study that estimated the homeless population at 500,000 to 600,000.⁴ This study was updated by a 1990 one-night nationwide survey of shelters and street locations "where homeless persons tend to congregate or stay," which found 179,000 persons in emergency shelters and about 50,000 at identified street locations. According to the council, the Census Bureau will soon begin counting people in transient campgrounds and shelters for abused women.⁵

While making an accurate survey of any homeless population is at best difficult, it is clear that the varied definitions and methods used make obtaining a common starting point even more problematic. The council also has a much different picture of the characteristics of the homeless than either Boston or the U.S. Conference of Mayors. The council found that three quarters of the homeless population were single males, people living in family groups constituted only 20 to 25 percent, and 80 percent were unemployed.⁶

The more influential the debaters, the more polarized the dialogue has become. The unfortunate but predictable results of high-level policymakers' preoccupation with the debate has been that the homelessness issue has been passed among housing and social service agencies. Each of the groups has claimed it was another's responsibility, and none focused sufficient resources on long-term solutions.

The preoccupation with the debate has also prevented the kind of national coalition building needed to find long-term solutions. If, for example, homelessness is a housing problem, then a glaring omission from the advocates' strategy appears to be the absence of the well-organized and powerful housing industry that so successfully lobbied for and produced low-income housing in the 1960s. In fact, the housing industry, which has yet to be included in the coalition, predicted the tightening in the private housing market that would lead many into homelessness.

In the early 1980s many American businesses were busy profiting from leveraged buyouts, watching stocks soar, and becoming rich through real estate transactions. To many it was unfashionable and to some even unpatriotic to dwell on inequality or predict financial doom. Yet that was just when the National Association of Homebuilders, a mainstay of American industry, issued an ominous warning.

In its major report, "Housing at the Turning Point: An Assessment of America's Shelter Needs for the 1980's," the association made its tragic prophecy: "Unless current trends are reversed soon, a housing crisis of unknown proportion could engulf this nation, pitting one generation of Americans against another and further pushing from the mainstream of American society those who are denied decent affordable housing — the young, the elderly and the poor." The association's warning became all too true. In the 1980s, homelessness — previously thought by many to exist only in cities like Calcutta — became a national scandal and dominated the news media.

But for many working in the housing field, there were other indicators of severe problems. Particularly in New England, the housing market was changing. While some high-income families were paying well in excess of a million dollars for a home, for the first time since World War II a far larger number of gainfully employed young families could not afford to buy one. Many elderly unable to find or afford needed services to help them live at home independently were forced prematurely into nursing homes. Rents for private apartments serving lower-income households soared way beyond any corresponding gain in wages or benefits. Indeed, when placed within the context of our nation's private housing market, a policy connection the industry seems to have made more easily than housing advocates, homelessness becomes understandable, if not solvable.

The Root of the Problem: Building for the Future

Far from the bustle of national policy debate, a different scenario was unfolding. On a local level, most community housing groups had stayed out of the debate and were far removed from the organized forces of the national housing industry. Local housing groups concentrated on developing programs and projects that provided both housing and the additional support residents needed to maintain or regain workable lives. They struggled with minuscule resources to find long-term solutions, and members of local real estate agencies often played central roles.

For the most part these were not Lone Ranger activities, but efforts that worked in conjunction with city and state governments, some of which relied on federal funds. Most noteworthy, these local groups were able to foster the broad-based coalitions that have thus far eluded nationally focused housing advocates. There are some common themes among these community-based projects and their cumulative

experience offers insights into criteria that can promote successful policies to combat homelessness. Some examples follow.

Most designers of community programs or projects see no contradiction between providing housing and whatever additional assistance the residents may need. The integration of housing and services is seen as a prerequisite for effective housing policy and may well prove to be one of the most important housing lessons of the 1980s.

The primary initiator or catalyst may have no professional qualifications at all but can quickly develop a working relationship with someone who does.

Designers integrate their projects with the community. Initiators who are not members of the community make local contacts early and incorporate local views in the planning process. These efforts are not viewed as doing something "to" a neighborhood, or even "for" a neighborhood, but "with" a neighborhood.

Local real estate interests are often considered part of the solution rather than part of the problem.

Project designers do not regard homelessness as an issue in and of itself, but as one component of a broader housing agenda. Programs that work to prevent homelessness and broaden housing opportunities are seen as vital to the strategy.

While the level, formality, and kind of support services vary greatly among projects, designers pay particular attention to the specialized needs of their clients on a project-by-project basis. The long-term viability of the service component is considered as vital to the project as the structural design of any building. The developing entity either has a managing and service coordinating capacity itself or incorporates one in the project early on.

Projects and support services are not designed to care for residents in a demeaning way but to foster independence. Some clients are seeking control over their own lives and accepting responsibility for their own actions for the first time. This sense of empowerment among residents is a crucial component to a project's long-term viability.

Innovative Approaches to the Problem

The Community Land Trust

For those committed to developing community housing, programs from the other side of the globe can make good neighbors. The concept of a community land trust traces its origins to Mahatma Gandhi's village development movement. Similar efforts in Israel, among Native Americans, and land conservation trusts across the United States influenced the concept when the Institute for Community Economics (ICE) began promoting trusts as an affordable housing tool in the 1960s.⁸ In the 1980s, the land trust became a leader in community housing.

As ICE explains its approach, a land trust acquires the land, thus removing it from the speculative market. Individuals, families, cooperatives, and other nonprofits can then lease the property on a long-term, often lifetime basis. Most leases may be transferred to heirs should the latter wish to continue using the land in accordance with the agreement. Although the residents do not own the land, they may own the buildings or housing units that stand on it. The land trust retains title to the land and has an option to buy the building(s) should the owner decide to sell. The sales price is adjusted to reflect investment, inflation, and depreciation. The adjustments give

owners a fair return on their investments and ensure that the housing remains affordable in perpetuity.

ICE has helped organize more than seventy land trusts in urban and rural areas across the country. The trust's flexibility has made it a workable tool for a broad range of housing options, including cooperatives, condominiums, single-family homes, multiple rental units, and elderly housing. Projects have worked equally well within cohesive neighborhoods and broad regional areas. For example, Rehabilitation Action for Improving Neighborhoods (RAIN) includes eleven tenant-controlled buildings, each with 130 housing units, on New York's Lower East Side. All the buildings were acquired from the city. One is currently occupied, two are nearing completion, and the rest are being renovated.

Ariel Diaz, RAIN's president, worked as a homesteader renovating the buildings every Saturday for five and a half years before he moved in. Yet as he told Debra Bechtel in *City Limits*, a local newspaper, "We were very afraid that some people were in this to make a profit." Homesteaders usually take properties of low value and do much of the renovation themselves to keep costs down. Without controls, owners could easily sell units for far in excess of the \$250 they paid to buy into the cooperative, thus fueling the speculative market. "We created a land trust. People can sell their apartment but it goes to RAIN. This way the apartments will always be for low- and moderate-income people. They'll stay affordable forever," said Diaz.⁹ He stresses that the land trust model does more than just renovate buildings. By helping to stabilize rents, the trust enables the neighborhood to remain economically and racially mixed, a community where the young and old can mingle. The community had a say in building design as well. Some of the first-floor apartments are wheelchair accessible, and others set aside for homeless families and the elderly.

RAIN's board of directors represents the community at large as well as those specifically involved with the apartments. Each building has one representative on the board. The technical assistance organizations that helped with the renovation and the community at large have two representatives. RAIN's board meets once a month; the organization's eighty-five members meet four times a year. Giving people control over their environment is fundamental to both RAIN and the land trust. "We're empowering people," Diaz told Bechtel. "This community is finally waking up. We're taking charge."¹⁰

The land trust model has also been tried successfully in New England. It would be hard to find a neighborhood more different from New York's Lower East Side than Canal Street in Brattleboro, Vermont. Yet a land trust is thriving there. In August 1989, Madeleine Kunin, then Vermont's governor, attended ribbon-cutting ceremonies for three renovated buildings that had previously been targeted for demolition. All are owned by the Brattleboro Area Community Land Trust. In describing the project, the governor noted, "This is not just about new wiring and layers of paint. We're talking about people's lives, about restoring their way of living." She also referred to the project as the "best of its type in the state."¹¹

The transformation wasn't easy. Kathleen Clark recalled for the *Brattleboro Reformer*, "If you lit a match in my house during the winter, the wind coming through the walls would blow it out. If you used the toaster and the can opener at the same time, you would blow a fuse. . . . If it rained outside, it rained in my kitchen and bathroom. I don't mean the roof leaked a bit. I mean it poured inside my house."¹² Following the ceremonies, Clark showed the governor her renovated apart-

ment. Though the rent is still \$440 a month, there are now three attractive bedrooms. The kitchen boasts new cabinets and appliances. Fresh plaster and paint make the apartment come alive. The fourteen apartments will be run as a cooperative with a buy-in price of between \$300 and \$500.

ICE considers Vermont a land trust showcase in integrating community efforts with municipal and state programs. Vermont's Housing and Conservation Trust Funds aggressively promote the land trust concept. Funded at \$20 million annually, supported by two major banks and the Burlington City Employee Pension Fund, and with 1990 proposals calling for a \$40 million allocation, the Housing and Conservation Trust Funds have helped to make Vermont a national leader in community-based affordable housing.

The Inner City Task Force

Late in 1986, Boston's housing market was still soaring and the banks had money. A minority developer with a solid track record was seeking financing for affordable housing and all of the prerequisites appeared to be in place. The city was providing land, state rental subsidies assured a positive cash flow, and the demand for the units was overwhelming. The proposal seemed like a perfect opportunity for a bank to work with a minority developer to show its sensitivity to community credit needs, an important criterion should it seek regulatory approval to expand business across state lines. But the loan officer was nervous — he had seen the morning paper. Another child had been killed in the neighborhood the previous night. It didn't matter how good the projects were. Unless the problems of drugs and crime were addressed, the bank was wasting its money. The loan officer also knew that there would be a public outcry if he said what he thought. So he praised the project, but gave it no money. He said he wished he could help, but his hands were tied by regulations. No one confronted the real issues, and another sound, affordable housing initiative was abandoned in the convenient quagmire of banking red tape.

Several months later the same concerns again raised their ugly heads, yet this time the playing field was bigger, the stakes higher, the players different, and the results far-reaching. The Massachusetts Housing Finance Agency (MHFA) was meeting with tenants in one of its buildings — only this wasn't just any building but one of the Granite properties.

Even the Granite story is different from other developments. No one on the MHFA staff knows exactly why these properties are called the Granites. Some familiar with their history say it's because they are composed of granite dug from the Quincy quarries. Others think a previous management company was called Granite. Whatever the origin of the name, the Granite properties — roughly 2,000 units of assisted housing scattered mostly in Dorchester and Roxbury — were already receiving special attention well before MHFA held what may well become its historic tenant meeting.

In the mid-eighties, HUD, the federal housing agency, foreclosed on the Granites and planned to sell the 2,000 units on a scattered-site basis to the highest bidder. Local officials were concerned. As market rents would undoubtedly rise beyond the reach of most of the current residents, many would be forced to move out. And with other affordable housing options unavailable, the existing crisis in low-income housing would surely escalate and perhaps force more people into homelessness.

The foreclosure plans produced one of the broadest-based housing coalitions ever to confront the federal agency. The Democratic Congressional Caucus and influential Republicans, including private developer Robert Beal and William Edgerly, chief executive officer of the State Street Bank, joined forces with city and state leaders, tenants, community groups, and Cardinal Bernard Law to persuade the agency to change its mind. The strategy worked. The Boston Housing Partnership (BHP), one of the nation's most successful nonprofit housing corporations, was named developer for roughly 925 of the Granite units. In a rare decision, the federal agency allowed the state, through MHFA, to transfer another 218 units — soon to be known as Package 5 into private hands. A lot was riding on these Granite properties. With 600,000 units across the country facing problems similar to the Granites' and the homeless population growing, many housing experts were waiting to see what would happen in Boston.

Indeed, the stakes were high when MHFA staff sat down with tenants to review renovation plans for the Granites. With discussions under way, MHFA staff soon realized that while everyone liked the physical plans for the buildings, the project wouldn't work unless something was done about crime and drugs. Yet in this case it was the tenants who could and did say it. "You might as well throw the money away unless you clean up the drugs and the crime," the tenants told MHFA staff. "No one would want to live here. The police won't even come." Unlike the nervous lending officer, MHFA did not shrink from the problem. "You can't solve these problems if no one is willing to talk about them," said Eleanor White, MHFA's deputy director. "No one likes to admit that drugs and alcohol are such big problems, but they are. Having the tenants say so really helped us do something about it."¹³

With tenant support, MHFA formed the Inner City Task Force. Made up of community representatives, tenants, and city and state officials, the task force addresses both the physical and social concerns affecting the Granite renovations on an ongoing basis. In essence, the task force, which has been meeting since 1986, provides a mechanism to link the physical housing issues with what tenants perceive to be the most important service, drug and crime control. The combined efforts of tenants who know the problems and public officials who have the clout to make things happen has made a difference. The Boston Police Department provides more patrols, and MHFA recently hired additional private security to assist them. Training sessions help tenants intervene when drugs or alcohol abuse are affecting someone who wants help. Programs are available for follow-up and long-term assistance to help break the dependency cycle. The message is clear: drugs will not be tolerated.

Nationally, the Inner City Task Force is the first of its kind to be run by a state housing finance agency. As Eleanor White, who became the task force's chairperson, explains, "As a lending institution, we aren't equipped to deal with the whole range of social problems in the inner city, but in this case we had to do something. On the one hand [the task force] is enlightened self-interest — a means of protecting our investment in these properties. On the other hand, it's a recognition that MHFA cares for much more than bricks and mortar — we care for people. The task force tries to support people and community as carefully as the financial analysts and technical staff assist the developers and builders who create and manage the dwelling units."¹⁴

The task force's work has been widely recognized. In Washington as HUD's Secretary Kemp seeks ways to get drugs out of federal housing, the Granite story con-

tinues to be retold. Indeed, empowering individuals to assume control over their own environment and lives is a growing theme expressed by such people as Jesse Jackson and mothers of drug-dependent children alike. And the fact that private lending officers and tenants in assisted housing can openly agree that crime and drugs are the major problems confronting housing development in our cities is a major step forward.

Intergenerational Housing: Young and Old under One Roof

From the outside, the large Victorian house framed by dignified trees at 186 Marlborough Street in Boston's Back Bay looks no different from her posh neighbors. Inside, her tiled entrance still offers an impressive passage to a stately hall complete with high ceilings, a massive formal fireplace, and elegant stairway. An equally grand drawing room, separated from the foyer by immense pocket doors, reminds visitors of the stately elegance that once pervaded the building. Yet 186 has a far more interesting story than many Back Bay homes. On his retirement from Emmanuel Church in 1929, the Reverend Elwood Worchester received the property — previously the rectory — as a gift. While most of his children grew up and moved on, the reverend and his daughter Constance not only remained but rented their vacant rooms to needy Back Bayers who sought to remain in the affluent neighborhood. After the reverend's death in 1940, Constance continued running the property as a lodging house. At the time of her death in 1986, eight people of all ages, including an expectant mother, made 186 their home, some paying as little as \$20 a week.

"Constance was a character," said her neighbor of forty-two years, Marion Ullman. She took care of people, which was good. But she had no idea how much things cost. She thought in 1930s terms during the 1980s. She'd never raise rents, yet costs would increase, so the building wasn't maintained. If you'd explain that comparable rents in the area were much higher, she'd simply say, 'Fancy that.'"¹⁵

Today 186 provides housing for young and old in an innovative program developed by Boston Aging Concerns—Young and Old United (BAC—YOU), a nonprofit agency with a solid record in elderly services. BAC—YOU purchased the property in 1989 for \$550,000 and renovated it as a lodging house for elderly and low-income Back Bayers, much in the same vein as Constance had run the property but with a more realistic financing plan to cover maintenance costs. The building includes sixteen units — eight studio apartments, one single bedroom, seven private rooms — and laundry facilities. Several tenants share a dining area, kitchen, and bath. The gracious first-floor living room has been retained for common use.

All the previous residents were allowed to return to the property after renovations. Generally, when all units are rented, 50 percent of the tenants are over sixty-two years old and 70 percent are over fifty-five. The remainder are younger low-income people, most of whom work in the Back Bay. Mixing young and old individuals in the same building helps fosters mutual support. Both groups enjoy affordable rents; the young have someone to look out for their rooms while they are away, and the elderly can rely on the young for errands or informal help.

The BAC—YOU program is more than just another interesting approach to affordable housing. Its intergenerational quality enables informal linking of services and housing for the elderly. BAC—YOU's professional management ensures formal coordination. In fact, the organization's strong track record in elderly services predates its

involvement in housing — and it was a client who convinced BAC to preserve homes like 186 as lodging houses.

Brad Day, an early member of Boston Aging Concerns wrote, “I’ll never forget the day we found Herb, one of our members, lying unconscious in the doorway of Boston Aging Concerns. We had known him over the years through our hot lunch program.” Herb, who lived in a lodging house, came home to find his door pad-locked — the new buyer had not even followed legal eviction procedures. “Herb,” Day continued, “slept on the street for the next eight nights until he ended up in a heap on the doorstep . . . Experiences like that one prompted us to get involved in preserving lodging houses and convert them into shared housing for the elderly.”¹⁶ There are a lot of Herbs among the homeless.

The supply of rooming houses, once a common source of decent housing for those of low income, was reduced by upscale renovations and condominium conversion in many cities. In the 1950s, roughly 30,000 Bostonians called lodging houses home. Fewer than 2,500 of these units remain. Today, however, almost everyone wants to bring them back. Since 1980, when BAC-YOU undertook its first renovation project, single-room-occupancy (SRO) housing, has been developed across the county. The federal government sees SROs as a mainstay in its fight to end homelessness and has pledged to help develop 2,000 units nationwide. Boston, responding to the federal challenge, launched its Rooms for More campaign to produce 1,000 rooms within the city.

As David Trietsch, acting director of Boston’s Public Facilities Department — the entity that coordinates city housing policy and programs — explains, “Providing affordable housing depends on both new construction and utilizing the existing stock. Viable lodging houses are one way to adapt or maintain units we already have for those most in need. We want to encourage them as one component of our housing strategy.”¹⁷

Lead Paint and the Brockton Area Help Line

“Lead paint” represents two words with a connection to homelessness that is not readily apparent. Yet lead paint poisoning, which can leave a child with severe and lifelong learning disabilities, has been a public health issue in Massachusetts for some time. Recently it has become a ticking time bomb for those responsible for housing policy. As with homelessness, many view the pending lead paint crisis as a by-product of misguided housing policies; in both instances, low-income children are the most likely casualties.

On the public health front, Massachusetts has been fighting lead paint poisoning since 1971, when the legislature passed a comprehensive lead poisoning prevention statute.¹⁸ The law deserved and received much praise. The need for action was overwhelming. Based on the higher definition of lead content that constituted poisoning at the time, 13 percent or 75,000 children under six were considered to be at risk statewide. Nearly 20,000 were actually poisoned. The Massachusetts law, considered by many to be a national model, provided for a statewide strategy with research, educational, and diagnostic components. It prevented the use of lead paint on a broad range of goods found in the home, from toys to cooking utensils to furniture. It also required the owners of residential properties where children under the age of six live to remove or cover leaded surfaces in accordance with stated guidelines. Property owners who failed to delead can be held liable for damages.

In the early 1970s, the Department of Public Health, charged with implementing the new law, set up the Childhood Lead Poisoning Prevention Program. As a public health effort, the program operated effectively on a shoestring budget of \$280,000. Funds were used to identify poisoned children and make their homes safe. Subsequent efforts ensured that affected children received medical attention. The number and severity of poisoning declined, but the program is not without its critics. While no one has suggested a better approach to safeguard public health, given the minuscule funding, some experts note that the program has used children as canaries. With such minimal funds there have been neither enough inspectors to determine the level of lead in a unit nor moneys to help homeowners or landlords delead. Only when children become sick is something done. Very little preventive deleading has been undertaken.

Conservative estimates indicate that at least 59 percent of the state's housing stock still contains lead paint. In Boston the figure is closer to 80 percent. Until 1961, the federal government required its stock to be painted with lead-based paint because colors were brighter and the paint lasted longer than other types. However, the federal agency responsible for this stock has been very slow to remove it. Without adequate public funding, the primary responsibility for deleading has fallen on homeowners and landlords. Too often, because deleaders have been neither trained nor licensed, deleading has proved to be worse than doing nothing. In addition, with low-income housing dwindling, deleading has emerged as much a housing as a public health issue. From the housing perspective, few argue that the program has severe shortcomings.

Avi Davis, for example, describes himself as landlord with a moderate number of properties in Jamaica Plain. His company, Innovative Movers, serves mostly Boston landlords and tenants. Davis is firm in upholding antidiscrimination laws. It is illegal to deny housing to families because of children. The law is clear: if a unit has lead paint, the landlord must delead and rent to the family; refusing to do so constitutes discrimination. Because of his stand on the issue, Davis estimates that 80 to 90 percent of the calls he receives from landlords seeking his representation are, in his words, "a waste of time. When they find out the alternatives they'd rather I didn't represent them."¹⁹

While Davis is quick to point out that some landlords would be unwilling to rent to low-income families even if lead paint were not an issue, he estimates that in one half to two thirds of the cases, lead paint is the reason. "Landlords don't want to be in the middle on either the lead paint or the discrimination issue," he explains. He does not see more rigorous enforcement of fair housing as either a likely or workable solution. "Many of the landlords can't afford to delead. Others, even if they could, would rather hold their units off the market for a month or two and rent them quietly. They don't need the hassle."

Valerie Schecheter, a housing advocate at the Bristol Lodge Family Shelter in Waltham, reiterates Davis's view. Schecheter, who was a broker for ten years before working directly with the homeless, clearly understands the issue from a housing point of view. She describes the situation as "awful."²⁰ Schecheter says that most of the housing she has worked with contains lead and that those who try to delead often create more of a problem than those who ignore the law. Many deleaders don't really know what they are doing. Well-meaning parents or "helpful" handymen often create a problem by scraping what they think is just old paint as part of routine

maintenance. As dust in the air, lead is even more dangerous and harder to keep away from small children than paint chips.

Schecheter also concurs with Davis's assessment that the lead paint law encourages landlords to discriminate against families with small children. It is clear that holding landlords responsible for a problem they did not create does not work. A carrot-and-stick approach is needed; thus far it has been all stick. The state is not oblivious to the difficulty of forcing landlords to delead while the homeless population grows. In fact, many shelters contain lead paint. Separately, homelessness and lead paint are difficult issues. Together, they force anyone trying to develop workable housing solutions on the local level to steer an almost impossible course between Scylla and Charybdis.

Therefore, many, logically, see a role for the federal government. In the summer of 1991, with great fanfare, the federal government lowered the amount of lead it considered harmful to children. Yet nationally it allocated only \$50 million in additional funding to assist states with deleading programs. While a Catch-22 in the new law may be good news for Massachusetts, it's questionable national policy. States must have an approved deleading program to be eligible for the funds; at the moment, only Massachusetts and Maryland, and possibly soon Rhode Island, qualify. Meanwhile, nationally the massive amount of lead in both the private and subsidized housing stock is clearly an environmental issue of superfund proportions. Yet EPA and HUD, the federal agencies responsible for the environment and housing, respectively, have shown characteristic slowness in dealing with both issues.

Within this federal vacuum, the state has made some progress toward a workable approach to lead poisoning. In January 1988 the legislature passed an Act to Further Prevent Lead Poisoning. This bill essentially brought the 1971 act up to date with advances in medical and environmental science. While in some respects the law is even tougher on homeowners and landlords than its predecessor, it was seen as containing a silver lining. Section 2 requires the Executive Office of Communities and Development (EOCD) to design a program to "assist residential property owners and tenants to finance deleading activities," and the state had a good local model to work from.

A coalition of various health and social service agencies working through the Brockton Area Help Line (BAHL) developed an extremely sensible approach to deleading. Rather than making the landlord part of the problem, the group talked to local Realtors and incorporated a housing perspective into the program, thus linking the remedy to two social problems. It worked like this: an owner interested in deleading agreed to rent to a BAHL client, a low-income family with a rental certificate. The owner signed a lease and an agreement with both the family and the BAHL. After the Brockton Board of Health determined that lead paint was present, the owner obtained two written estimates from deleading companies on a BAHL-approved list. If the cost of deleading a unit was under \$1,000, the landlord agreed to rent to a BAHL family for one year; for units that cost between \$1,000 and \$2,000 the lease was for a two-year period; and those costing between \$2,000 and \$3,500 required a three-year lease. When deleading and repainting had been done, the Board of Health again inspected the unit to verify the absence of lead. The landlord paid the deleader and was reimbursed by the BAHL.

The BAHL approach was so reasonable that it is difficult to believe it has not been replicated. Carolyn Chace, director of Housing Services for the BAHL,

explains that the program helped house homeless families while keeping rents at a reasonable level. "Not all landlords want to be the next millionaire. Some would like to feel they are helping. Many have kids themselves. They just don't want to end up in court to do it."²¹

With \$60,500 the BAHF deleaded approximately thirty-three units. Based on the average \$40-a-day cost to keep homeless families in a hotel or motel, the program paid for itself in about two months. That price does not even begin to count the human or economic cost of one child being poisoned. The program has received broad praise from many poison prevention experts. Paul Hunter, director of Field Operations for the state's Childhood Lead Poisoning Prevention Program, knows as much as anyone about lead poisoning. Noting that some 350,000 children were still at risk, he urged that the Brockton approach be adopted by the state. Preventive deleading is crucial. If the state really wants to make homes safe, it must offer some sort of financial incentive for landlords.

Given the state's fiscal crisis, developing financial incentives has proved far more difficult than was envisioned in 1988. Unfortunately, no funds have been allocated to replicate the BAHF program, and cuts in state housing subsidies make even that program obsolete. The state housing financing agency has made a start with a \$5 million commitment to assist owner-occupants in deleading their structures, and proposed tax credits are seriously being considered as a way to finance the deleading of housing owned by investors. Nevertheless, no one assumes that these programs will provide enough assistance. Nor is it clear how either of these approaches will assist the homeowner who is barely able to pay the mortgage or the investor who is just a step away from abandoning the property. Perhaps the most distressing aspect of the law from a housing perspective is that, without adequate financial assistance, enforcement becomes the only incentive to delead, and enforcing the law in this tough economic climate creates enormous problems for low-income families, real estate interests, banks, and insurance companies.

However, all the news on the lead paint front isn't bad. In October 1991, the Massachusetts Association of Community Development Corporations (MACDC), a well-respected coalition of nonprofit housing developers, sponsored a lead paint awareness day. While the prevailing perspective was still that of public health, there was clearly a growing recognition of the serious housing implications inherent in deleading policies. Most of the fourteen cosponsors were housing groups.

Rebecca Goldberg of MACD, the event coordinator, is clearly knowledgeable about the wide array of public policy issues inherent in the lead paint issue. "Lead paint was once seen as a public health issue," she said. "It's still that, but it's also an environmental, banking, insurance, and housing issue. My dream is a piece of legislation that reaches all of those groups."²² A very important coalition may be coming together. Many of its members, if they joined forces on the regional and national levels, could do much to solve the problem of homelessness.

The Need for Innovation

As this article has attempted to show, the land trust, the Inner City Task Force, intergenerational housing, the Brockton Help Line and MACD's work on the lead paint issue are examples of local initiatives that provide affordable housing. Ironi-

cally, these and other successful housing efforts of the 1980s are very far removed from national housing organizations. Although the Homebuilders Association accurately predicted the problem, it has had a far more difficult time finding solutions. The greatest challenge of the 1990s may be to incorporate the lessons of these community initiatives into the mainstream of America's housing providers.

New England has a unique opportunity to forge such a partnership. Channel 5's experience demonstrates that the public wants to solve the problem of homelessness. The large inventory of foreclosed and troubled properties offers what may be the last chance for entities serving low-income people to buy housing for less than they can produce it. The continuing loss of capital these unsold properties represent provides new incentives for bankers, real estate interests, and insurance companies to join the housing advocates in developing sound housing policy, and ultimately, solutions to homelessness. The public has the will; local efforts have shown the way. Regional and federal leadership is desperately needed to respond to the challenge. 29

Notes

1. Sheila Kennedy, "Homeless," *Boston Magazine*, November 1988, 300.
2. U.S. Conference of Mayors, "A Status Report on Hunger and Homelessness in America's Cities: 1991," 25-27.
3. Interagency Council on the Homeless, "What Are the Causes of Homelessness?" no. 7 (May 1991).
4. Interagency Council on the Homeless, "How Many Homeless Are There?" no. 1-1 (April 1991).
5. Ibid.
6. Interagency Council on the Homeless, "What Are the Characteristics of the Homeless Population?" no. 2-1 (April 1991).
7. Sheila Kennedy, "Housing Innovations," *Banker and Tradesman*, March 14, 1990, 3. I conducted significant portions of my field research for *Banker and Tradesman* from 1988 through 1990. This material is used with the publisher's permission.
8. Ibid.
9. Ibid.
10. Ibid.
11. Ibid.
12. Ibid.
13. Ibid., July 26, 1989, 4.
14. Ibid.
15. Ibid., May 3, 1989, 3-4.
16. Ibid.
17. Interview with David Trietsch, January 15, 1992.
18. The most recent Massachusetts lead law was enacted as Chapter 773 of the Acts of 1987. Although references are made to the law in several places in the state's general laws, sections 190-199A of Chapter 111 primarily address this issue. (Source: Conservation Law Foundation.)
19. Kennedy, "Housing Innovations," May 15, 1988, 4.

20. Ibid.

21. Ibid.

22. Interview with Rebecca Goldberg, January 9, 1992.

Ending Homelessness among Mentally Disabled People

Steven A. Hitov

This article examines some of the many shortcomings of the mental health system operated by the Massachusetts Department of Mental Health (DMH) and explores the impact of that system on single homeless individuals who suffer from some form of serious or long-term mental disability. To afford that discussion context, however, the article first briefly examines those forces which have, and have not, significantly contributed to the large number of mentally disabled homeless persons. It suggests certain changes, including a shift in departmental focus from hospitals to community services and the creation of a housing subsidy system exclusively for DMH clients, which would allow DMH to end its current practice of at best ignoring, and at worst actually causing, the homelessness of mentally disabled people.

The Deinstitutionalization Mythology

When discussing the disproportionate¹ presence of mental illness among individuals who are currently homeless, one is often encouraged to address the relation between that phenomenon and the process of state mental hospital deinstitutionalization that has been under way for approximately thirty years. This is not a useful undertaking for several reasons. First, it assumes that there is somehow a significant causal relationship between the two. At least for Massachusetts, this is demonstrably incorrect. A study of homeless adults done for the state Department of Mental Health (DMH) determined that the "average" such person was thirty-eight years old, and that just about half the population was under age thirty-five.² While DMH has reduced its inpatient population from 20,000 in 1960 to just over 2,000 today,³ over half of that decrease was accomplished by 1970. Further, the people discharged during that period had typically been institutionalized for years at a time. Thus, they could not, as a group, represent the currently homeless unless DMH hospitalized and discharged them when they were veritable children. Otherwise they would now simply be too old to yield the profile revealed by the DMH study. Whatever their fate, those who were discharged and neglected twenty-five years ago do not constitute a significant percentage of today's homeless.

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A second shortcoming of focusing on deinstitutionalization is its suggestion that homelessness among those who suffer from a mental disability is somehow a medical rather than a social problem, one that has presumably resulted from prematurely discontinued treatment. At best this entices one and, as we shall see, has led DMH to focus on varying forms of "treatment," rather than housing, as a potential solution. At worst, it suggests that reinstitutionalization may be a viable response to homelessness. The data on this topic simply do not support such a conclusion. In separate studies conducted in Massachusetts, New York, and Ohio, researchers determined that while approximately 30 percent of the homeless people they interviewed had major mental health problems and most of them needed *some* mental health services, only 5 percent to 7 percent would even benefit from, much less require, inpatient care to meet their needs.⁴ Unless we as a society are willing to forcibly hospitalize vast numbers of people who do not require such care in order to "capture" the relatively few who might, reinstitutionalization cannot possibly be viewed as a rational response to the problem of homelessness among those with mental disabilities. This is particularly true when one considers that the current average cost of maintaining a person in an institution in Massachusetts ranges between \$126,000 and \$178,000 per year.⁵ Even people who are so frustrated with the persistence of homelessness that they might otherwise be tempted by this "out-of-sight-out-of-mind" approach must rethink their position or be willing to shoulder enormous tax increases in support of their viewpoint.

Unfortunately, the focus on deinstitutionalization is not merely a benign mistake. It serves both to misdirect one's attention when searching for solutions, and also, intentionally or otherwise, to obfuscate the fact that the current crisis of homelessness is the direct and predictable result of more than a decade of government policies aimed at dismantling the very structures that formerly allowed large numbers of desperately poor people to maintain a home. While the correlation between the Reagan administration's attack on public and subsidized housing⁶ and the current rise in homelessness is now widely recognized as a true social disaster, it is one that predictably had a disproportionate impact on poor people with mental handicaps, who regularly lose out when competing with others for increasingly scarce housing resources.

Compounding the woes of this already embattled group was the less well-known attack that Ronald Reagan waged specifically against them. Between 1981 and 1983, the Social Security Administration arbitrarily terminated the Supplemental Security Income and Social Security Disability benefits of approximately 50,000 people who suffered from mental disabilities.⁷ While subsequent lawsuits were successful in having benefits restored to two thirds of those who had been terminated, that still left almost 17,000 people with mental disabilities without what was almost certainly their only source of income. It is the stuff of fantasy to assume that large numbers of these people did not become homeless as a result of having that income abruptly terminated.

In addition, it is almost certain that significant numbers of those who ultimately had their benefits restored were nonetheless rendered homeless, given that landlords are neither required nor inclined to forgo collecting rent while tenants are busy disputing the actions of the federal government. Once housing is lost, the restoration of benefits often does little to help an individual regain a place to live, for the front-end costs of acquiring housing (first month's rent, security deposit, finder's fee, and moving expenses) are almost always beyond the ability of a poor person to pay.

Thus, deinstitutionalization in fact has had little to do with the current general epidemic of homelessness among the mentally disabled. When the federal government

decides to wage a war on the poor, it should come as no surprise that the most vulnerable among those living in poverty will be disproportionately affected. Given that the Reagan administration's economic smart bombs were specifically targeted upon affordable housing and people with mental disabilities, it would indeed be a minor miracle if the mentally ill were not overrepresented among the single homeless.

DMH's Inside-Out Service System

While it is incorrect to focus on deinstitutionalization as *the* cause of homelessness, it is nonetheless important to recognize that the mental health system operated by DMH does regularly contribute to homelessness among the mentally ill, both directly and indirectly. As this part of the article will demonstrate, the "medical model" of service delivery utilized by DMH has largely been, when viewed either economically or as a matter of social policy, a failure for everyone except the professionals who staff it, and has proved especially ineffective in addressing the mental health needs of the homeless.

The current system has historically, conceptually, and financially always started with hospitals, and only then, almost as an afterthought, considered other options for allowing people with mental health problems to continue or resume functioning as contributing citizens in their communities. The results of such a hospital-centered, doctor-driven approach are, as a matter of resource allocation, quite appalling. DMH is currently expending 42 percent of its resources (over \$192 million) on inpatient care, which serves only 6 percent of its clients.⁸ As of May 1991, more than 500 of 2,156 inpatients⁹ were being detained solely because DMH had not located or developed sufficient community placements for them.¹⁰ So, in addition to spending enormous amounts of money on a tiny fraction of its clients, DMH is expending almost 25 percent of that sum — more than \$45 million — on people who, it admits, do not require, and almost certainly do not desire, such care.

Unfortunately, the misallocation of resources is not the only, or even necessarily the most egregious, cost of the DMH service delivery system. The hospital-centered medical model views life in the community as a privilege to be earned by those who have required hospitalization. All DMH inpatients, regardless of their condition, start with enforced confinement¹¹ on a locked ward — sometimes in seclusion — and then proceed to earn the "privilege" (so described by the DMH Inpatient Policy Manual) of increased freedom. Initially a person may be given permission to go to unlocked parts of the facility, then onto the grounds, and ultimately to visit the community. At all times, however, even this limited freedom is subject to the person's willingness and ability to comply with all of a facility's rules, no matter how petty or seemingly unrelated to treatment. Independence, either of thought or action, is not a characteristic highly valued, or wisely exhibited, within a DMH facility. The inpatient system is so control oriented that, regardless of treatment needs, facilities have been known to discharge people directly to the streets or to shelters, even in the dead of winter, because of perceived violations of "program" rules (such as taking legal, but unprescribed, medications). In short, the inpatient system is one in which clients are afforded only rudimentary rights and client choice has little or no meaningful role.

If one then views community placements, as DMH does, as a person's "next step" following an inpatient experience like that just described, it is not surprising that DMH has chosen to develop "programs," rather than housing, for those seeking to

return to the community. Of the approximately 3,255¹² people now being served in DMH residential settings, probably fewer than 100 are residing in DMH's most touted independent living initiative, apartments administered by the Massachusetts Housing Finance Agency (MHFA) to which DMH and the Department of Mental Retardation have negotiated access.¹³ The vast majority of people who count on DMH for residence in the community are living not in houses but in programs.

Programs differ from housing in several critical respects, both in human and financial/development terms. First and foremost, programs reflect the medical model mentality that perceives people with mental disabilities as perpetual patients, with the resultant infantilization that so often accompanies that status. Additionally, or perhaps merely as an example of that infantilization, programs often require unrelated adults to share not only their housing, but even their bedrooms. Nearly 65 percent of the settings for DMH residential services are located in buildings in which only other DMH clients live.¹⁴ In nearly a third of those settings, people are forced to share their bedrooms with someone not of their choosing.¹⁵ This is not how most adults choose to live, and even DMH recognizes that it is often clinically dysfunctional.¹⁶ Groups of eight unrelated adults simply do not often choose to live together. Indeed, the skyrocketing national divorce rate suggests that more and more groups of two are experiencing difficulty in achieving this feat.

Nonetheless, communal living is exactly what DMH demands of most of its clients in residential programs. The stress of such an environment is compounded by the fact that a person must conform not only to the norms of general tenancy, but also to any treatment requirements that DMH decides accompany the program. In this way, programs perpetuate the control and compliance regimes of the inpatient facilities. Should someone decide that he does not like or no longer needs the type of treatment that is being offered in a given program, he is faced not only with the loss of services but with the specter of imminent homelessness.¹⁷ This is hardly an environment in which one is likely to question the services being rendered. As a result, consumer choice and input, and ultimately the quality of any services offered, are also victims of the current DMH system.

At the opposite end of the human experience spectrum, but of equal importance, is the situation in which a person is quite happy with a given program and therefore flourishes in it. Such a scenario suggests a happy ending, but that is not always the case. A person who has come to consider a program of a given intensity level to be home, and thrives there, risks being removed from her home exactly because she is doing so well. The "better" she does, the greater the chance that she will have to move to a lower intensity program so that someone else can benefit from the program she found to be so rewarding. While from a medical perspective the person might be expected to be joyous about her perceived improvement, from a human perspective she is more likely to be distraught at the prospect of losing perhaps the first true home she has known. Perversely, this possibility builds in an incentive for a person not to do too well if she indeed likes her situation. Thus, even an apparently "successful" program may prove in the long run to be injurious.

Human costs are not the only ones associated with a system that assumes it must provide residential programs in order to return people to the community. While it now appears that, as a result of the Governor's Special Commission inquiry, Massachusetts has finally decided to address the abysmal condition — both finances and quality of care¹⁸ — of its public inpatient psychiatric facilities, that undertaking is

being made more difficult by the method of community service delivery utilized by DMH. The commission has called for the creation of 700 additional community placements by the end of June 1993 to accommodate current inpatients¹⁹ who do not now or will not by then need inpatient care. This initiative is part of an overall plan to reduce the inpatient capacity of state facilities while, it is hoped, improving, but at a minimum not reducing, the quality of care currently being provided to anyone.

The commission has identified two major problems in accomplishing the creation of the additional community placements. Both, as it turns out, are problems that exist solely because of the limited approach to community care employed by DMH. First, because so many of DMH's present and projected residential settings are program oriented and congregate in nature, they require substantial lead time, and money, just to acquire and develop the property in which they operate. Consequently, the ability to respond even to anticipated need is quite limited. The financial and logistical ability to accommodate unanticipated demand is nonexistent. This reality has led DMH to perceive that it is caught in a chicken-and-egg situation in which it recognizes that it can save money by discontinuing unnecessary inpatient care, but cannot afford to do so because it lacks the finances and properties necessary to provide more appropriate and cheaper, but by no means inexpensive,²⁰ care in the community.²¹ Thus, the entire system is constantly backed up by the difficulty of developing programs of varying intensity levels necessary to respond to ever-changing client need.

Unfortunately, as the commission report also recognizes, the problems for the typical DMH community residential program do not end when the money has been found to finance it. Because the programs so often create congregations of DMH clients, the now familiar NIMBY (not-in-my-back-yard) syndrome regularly rears its provincial head. Neighborhoods and even whole cities all too frequently attempt to erect barriers to the siting of community residences. While the law is increasingly clear that such efforts are illegal, defeating them and winning over a neighborhood is both difficult and time-consuming work. Moreover, it is work that often turns what should be a very private affair, namely, a person's desired choice of residence, into a public, if not a political, debate. This process only exacerbates the already lengthy delays inherent in developing necessary community resources.²²

The inability of the current community residential system to respond on an "as needed" basis has a disproportionate negative impact on homeless individuals with mental disabilities, many of whom are "pink-papered," that is, forcibly admitted pursuant to M.G.L. c. 123, §12, to DMH inpatient facilities following acute psychiatric episodes on the street. Such individuals definitionally enter the facilities in need of housing as well as acute care, but their inpatient stays are often quite short, varying in length from overnight to one or two weeks. While, as a matter of law, people admitted pursuant to Section 12 are entitled to an individual service plan (ISP) designed to assess and address both their medical and social needs,²³ in practice ISPs are almost never afforded to such short-term inpatients. As a consequence, the homeless mentally disabled receive virtually no assistance even in applying for the public benefit programs for which they may be eligible before they are again discharged.

Further, because of the chronic shortage of community placements and the inherent difficulty of creating and siting new ones of the type now most often utilized, it should come as no surprise that DMH maintains lengthy waiting lists for such placements and is reluctant at best to insert a more recently admitted inpatient at the top of such a list simply because he happens to have absolutely nowhere to live. As a

result, homeless individuals who have been pink-papered to DMH facilities are regularly discharged by those facilities right back to the street or to a singles shelter, where they must sleep in crowded, open barracks with numerous other equally poor and otherwise troubled people and walk the streets from dawn to dusk each day while the shelters are closed. As one might easily predict, many of those so discharged quickly wind up back in the facility, often in worse condition than upon their initial admission. This practice is so pervasive, and so inherently clinically inappropriate, that in the past year, following two years of ultimately fruitless negotiations, two separate lawsuits seeking to curtail it have been filed against DMH.²⁴

The present system constantly undermines independence by demanding and rewarding compliance, in the guise of teaching personal responsibility, and enforces that demand by tying it directly to the provision of housing. It is a system that is both enormously expensive and wasteful, at least partly because it continues to elevate the perceived need for treatment above the obvious need for food and housing. In short, it is a system in need of a total overhaul if it is ever to achieve the national goal, set forth in the recently enacted Americans with Disabilities Act,²⁵ of integrating as many disabled citizens as possible, as fully as possible, back into the community.

Providing Housing with Desired Supports

As the Governor's Special Commission has determined, the entire DMH delivery system must be revamped if it is ever to operate effectively and efficiently. Many of the reforms suggested in the commission report are worthy of careful consideration and likely to lead to more humane service. Certainly the general thrust of the report, that citizens with mental disabilities are both better and more efficiently served in their community, is one that should be embraced as a matter of public policy, but in any event will soon have to be adopted as a matter of law.²⁶ Nonetheless, despite its considerable merits, the commission report's approach to actually providing community residential options can best be described as "do more of the same." As noted above, such an approach, if not doomed to failure, is at least so cumbersome that it is probably politically impossible to sustain the will to accomplish it. More important, it would merely perpetuate, although relocate, the segregation and disempowerment of the mentally disabled. Hence, at a time when Massachusetts is finally taking a hard look at its mental health system, it is critical that it start down the road toward a delivery model that will actually work.

The cornerstone of a functional community mental health system must be stable housing that is not conditioned on a person's willingness to participate in treatment. Only in this way can DMH overcome its addiction to the medical model that has been such a dismal failure at realizing community care. The separation of housing from treatment will foster the very independence that DMH purports to desire, as it will for the first time allow services to be consumer driven. When not faced with the Hobson's choice of accepting all offered services in order to be housed or rejecting those services and facing homelessness, people will clearly indicate which services they find helpful by utilizing those which are and rejecting those which are not.

This is not to say that persuasion should be forsaken as an option, or that people should not be made aware of the possible adverse consequences of any given course of conduct. However, it will force such persuasion to be just that, and not coercion. Such an approach, in turn, will offer DMH planners useful guidance in future pro-

gram development and offer private not-for-profit providers a market incentive to be responsive to the perceived needs and preferences of their consumers. In short, citizens with mental disabilities will actually have a meaningful voice in meeting their needs.

If housing is to be the foundation of the community mental health system, how is it best provided? The answer to this question must take into consideration the problems that the mentally disabled have traditionally experienced in gaining access to housing. DMH has realized since at least 1985 that part of the cause of homelessness among those with mental disabilities is that such people regularly lose out when competing with other groups for any scarce resource, especially housing.²⁷ Therefore, any housing assistance provided in conjunction with a true community mental health system must be targeted and reserved exclusively for the mentally disabled.²⁸ Further, it must be designed to afford the target population the greatest choice possible, in order to redress the past and present proclivity of society (and DMH) to segregate those with mental health problems. Next, it must be reasonably plentiful, so that DMH can eliminate the dual shameful practices of unnecessarily detaining those who do not require inpatient care and discharging vulnerable people directly to the streets or to overcrowded and devitalizing shelters. Finally, but of paramount importance if the system is to address the issue of homelessness among the mentally handicapped, the housing must be affordable. Market-rate apartments in Massachusetts Housing Finance Agency developments are no answer for this population.

Fortunately, an option exists that would meet all the above criteria. Rather than attempting to "develop" either residential milieus or even housing, DMH should immediately implement a housing subsidy program funded, if necessary, entirely with current mental health dollars. The program would operate much like the federal Section 8 Existing Housing program, which requires a person to pay no more than 30 percent of his or her income toward a predetermined fair market rent (FMR) for existing private housing in the community, and then pays the landlord the difference between the tenant's share and the FMR. The program would be available only to those eligible to receive services from DMH who lack an appropriate, affordable place to call home. If financially necessary, it could be further limited to DMH's priority population, those with a serious or long-term mental impairment. Thus, a finite population eligible for such a housing benefit²⁹ would not be competing with the general population to acquire it.

Included in the eligible population, whether defined broadly or narrowly, would always be those who have been admitted as inpatients at a DMH facility. This, in conjunction with the housing search and other ISP services discussed below, should completely eliminate both the long waiting lists for placement and the discharge of homeless people to the streets or shelters. Few have claimed that there is a shortage of housing in this country, only that there is a critical shortage of affordable housing. By operating its own subsidy program, DMH would gain for its clients ready access to the existing private housing market, which, especially when the rental market is soft, is only too eager to rent to those whose rent payments are government guaranteed. Because the subsidies would be mobile and travel with the mentally disabled, the program would also accomplish community integration to the maximum extent possible while achieving the generally accepted programmatic benefit of having service dollars follow the beneficiary, not the provider.

Finally, the subsidy must not be tied to the acceptance of treatment or services of any kind. Rather, it would be available to any DMH (priority) client who lacked a suitable place to live. While clients might reasonably be required to listen to what other services existed, they would be entirely free to reject them all and accept only the housing subsidy.

Among the services available must be knowledgeable and flexible assistance in searching for habitable housing. While such a service would assist people to find housing, it would not decide which housing a person would choose or with whom, if anybody, the person should live. It would be fine for two or more people to choose to live together, but such a living arrangement would never be forced on anyone. The Massachusetts experience with housing search workers employed by the Department of Public Welfare (DPW) to help homeless families locate qualifying apartments is quite instructive regarding the value of this kind of assistance, as is the method utilized within the Homelessness Unit of Greater Boston Legal Services (GBLS). Before the recent softening of the housing market, only about 50 percent of the unassisted families with Section 8 certificates were successful in renting an apartment before their certificates expired.³⁰ In contrast, over 90 percent of the families who had housing search workers assigned by DPW were able to rent within the same time frame. This discrepancy in results reflects the irrational and labyrinthine nature of the country's affordable housing system and demonstrates graphically that it takes professional help for almost anyone to negotiate it successfully.

While citizens with mental disabilities, taken as a group, may be more difficult to house than poor families,³¹ I, in my job assignment to break down the legal barriers facing homeless mentally disabled people, have so far failed to house only one of the clients who have sought assistance from GBLS in the past two years. Once GBLS is successful in acquiring a housing subsidy for a client, it assigns a student intern from the Boston University School of Social Work to work with that person to locate a qualifying apartment owned by a landlord willing to participate in the program. Like interns in a law office, the students can offer their opinions to clients, but ultimately it is the clients' wishes that control. If a client chooses to make a "bad" decision, that is his or her right. In fact, our clients have made very few such decisions (at least in my opinion) and have proved to be every bit as diligent and creative in their housing search as one might expect from a person afforded the possibility of access to a decent, affordable home for perhaps the first time in his or her life.

Nonetheless, the social work students play a valuable role in the process. First, they provide a nonjudgmental companion with whom the homeless disabled person can share any anxieties that he may be experiencing in the search process. They also provide a "professional" presence when the client interviews for a particular apartment, thus overcoming or easing the unfounded fears that a landlord may have about dealing with a mentally disabled person. Finally, the students are willing "to do what it takes"³² to ensure a successful result. So far, this category has included such endeavors as helping a client acquire and move furniture on a Saturday, purchasing two telephones (one was stolen on the client's last night in a singles shelter) so that he would not feel isolated in the new apartment, and arranging to have a broken television repaired to provide a client with entertainment and company. This is exactly the sort of hands-on approach that is sometimes necessary and that DMH must be willing to provide.

Again, the mechanism exists to do the sort of housing search to ensure that the proposed DMH subsidy system will work. DMH employs large numbers — although

never enough — of case managers, who are supposed to help plan an inpatient's smooth return to the community. While case management is another DMH service that has suffered at the altar of hospital worship, it must and can be revived to serve citizens in the community. A good start in this direction would be to employ ex-patients as case managers and assistants to case managers. They would bring a wealth of experience and understanding to the job and, predictably, be more willing "to do what it takes," nonjudgmentally, to help a person avoid what is often the horror of institutionalization. As one New York consumer case manager ironically explained, his employment has allowed him to look back on his twenty years of institutionalization not simply as a maddening waste of his life, but also as on-the-job training for his new endeavors.³³ Employing ex-patients for this purpose can only benefit everyone involved.

Whatever the source or background of case managers, there must be many more of them and they must be trained, at a minimum, to do housing search and public benefits applications for people who desire those services. It is a veritable crime that so many obviously disabled homeless individuals pass through DMH facilities without anybody's assisting them to acquire the Supplemental Security Income (SSI) and Social Security Disability (SSDI) benefits to which they are almost certainly entitled. Locating homeless individuals and getting them to apply for assistance are two of the major hurdles in maximizing their income. In addition, an application for either SSI or SSDI requires substantial medical documentation.

Thus, it is absurd that when DMH is holding such a person in a hospital, it makes no effort to see that the person receives these federal benefits. Instead, homeless people are disgorged as they enter, often with either no income at all or the lesser, but entirely state paid, stipend available from General Relief. Therefore both the individual and the state are worse off financially because of DMH's current practices. Case managers and other DMH employees who learn nothing but housing search and income maximization will have gone a long way toward increasing the stability of life in the community for many citizens with mental disabilities.

Once DMH has, as part of its mission and *raison d'être*, provided affordable housing, facilitated access to public benefit programs, and offered employment to those who need and desire such assistance, it can begin to offer other, treatment-oriented services to assist clients to maintain and enjoy their place in the community. As previously noted, these services, by becoming consumer driven, will be more likely to exhibit the flexibility necessary to accommodate the individual needs and preferences of the people they are designed to serve.

What then is wrong with this seemingly wonderful system? The answer, in short, is nothing. The two concerns most often raised by those wed to the medical model of control and compliance are that the system is viable only for the less impaired and that it would be too expensive to implement. Neither claim is supported by the available data or by experience in other states that closely resemble Massachusetts in size and nature.

In 1989, the Center for Community Change through Housing and Support conducted a national survey of 378 supported housing programs.³⁴ It evaluated programs using criteria that included basing housing on people's choices, using integrated regular housing, providing flexible supports, not imposing program requirements, and maintaining housing during periods of crisis or hospitalization. In other words, it sought and found programs operated pursuant to the approaches described in this article. The survey discovered that individuals served in supported housing settings

tended to be more, not less, disabled than those served in more traditional residential programs. Because the system is premised on stable, varied housing options buttressed by flexible service supports, the severity of the handicap that can be accommodated is limited only by the creativity of those providing support.

Nor would a model premised on the provision of a housing subsidy to each DMH client who lacked a home cost any more than the current system. Indeed, it could operate much more effectively than the present system for less money than is now being spent.³⁵ A single person can be subsidized in his or her own apartment in Massachusetts for no more than \$5,000 per year, or just over \$400 per month.³⁶ This is an incredible bargain when one considers that the cost, largely underwritten by state and municipal governments, of maintaining a person in a singles shelter is more than \$30 per night, or almost \$1,000 per month. For the cost of inappropriately sheltering each mentally disabled person, DMH could affordably and, even with absolutely no services, more appropriately house two of them.

DMH and the city of Boston statistics indicate that, statewide, somewhere between 500 and 2,500 people who are "on the street" might need and qualify for the subsidy proposed here. Even using a worst-case scenario, each of those people could be housed for a total annual cost of no more than \$12 million. If one then factored in the 500 people being detained solely because DMH lacks a more appropriate place for them, the total annual cost of housing all those DMH clients who needed it would be \$15 million. As we have seen, DMH acknowledges that it is currently spending three times that amount annually just to detain inappropriately the latter group of 500 people.

The short-term savings are compelling, as is the flexibility such a system affords. Since a subsidy is simply money, it entails no development time. So DMH could accommodate fluctuations in demand for the most difficult component of community care, space, without either lengthy delays in times of increased demand or vacant buildings when demand wanes. Further, but of critical importance, the existing private housing would be dispersed throughout the community, thereby avoiding the siting problems incurred by more concentrated housing arrangements and best serving the national goal of maximum integration. Necessary and desired services and supports would then be supplied where the client lived, rather than the client being made to live where those services are available, but not necessarily desired. The system would benefit the disabled and other community members alike. Even those DMH clients who continued to require long-term inpatient care would benefit by hospitals of a more manageable size with a staff better able to pay attention to each individual's needs.

However, a DMH subsidy program would most dramatically benefit the "homeless mentally ill." The medical model looks at this group and sees mentally disabled people who happen to be homeless. Starting from this perspective it attempts to "cure," or at least control, the illness, and refuses to or has no professional interest in housing those for whom treatment proves unavailing. A true community model of care based on affordable housing would view the same group as homeless people who happen to have a mental disability. Even, or perhaps especially, if their homelessness is caused by or related to their mental disabilities,³⁷ it makes absolutely no sense, either medically or socially, to ignore the symptom — homelessness — because the infirmity cannot be corrected. A similar approach with regard to a physical disability would have doctors refusing to prescribe painkillers for a person with a chronically bad back because they could not, or the patient would not let them, diagnose or cure

the cause of the pain. Each of these approaches is equally absurd, but only the former is practiced.

DMH should provide a subsidy to each of its clients who requires one in order to avoid homelessness, whether or not the person is interested in any of the other services that the agency may have to offer. This is exactly the approach, taken in Ohio and New York, which is getting rave reviews from the mental health professionals responsible for administering the programs.³⁸ Indeed, exhibiting a rationality rarely demonstrated by a bureaucracy, New York has included such assistance as a furniture grant and an emergency needs fund to ensure that those it discharges from its inpatient facilities do not end up both mentally disabled and homeless. The essential point is that even if the former condition is considered a given, the latter need not be.

Equipped with the proper perspective, a targeted subsidy program and flexible supports, DMH could end homelessness among the mentally disabled population of the commonwealth almost immediately. Further, it could do so without spending any more, and perhaps less, money than it now does. At a time when its delivery system is being reexamined anyhow, DMH should jettison its reliance on a medical model that has arguably contributed to, but unarguably failed to address, the problem of homelessness among those with mental disabilities. By adopting a subsidy system just for its clients, with services developed to address their expressed needs, DMH would provide better care, integrate and empower the disabled as the law will soon require, and perhaps most important, end homelessness among that portion of the commonwealth's population for which the Department of Mental Health is legally responsible. ♪

Notes

1. For health planning purposes it is generally assumed that approximately one percent of the overall population suffers from some form of serious or long-term mental illness. The best available data concerning the single homeless suggests that roughly 30 percent of that population has serious mental health problems. See note 4 and accompanying text.
2. See Virginia Mulkern, *Homelessness Needs Assessment Study: Findings and Recommendations for the Massachusetts Department of Mental Health* (1985), ii. Hereafter cited as *Homelessness Needs Assessment*.
3. Boston Emergency Shelter Commission, *Commitment and Compassion* (Winter 1990–1991): p. 10.
4. See Mulkern, *Homelessness Needs Assessment*, and *Access*, a publication of the National Resource Center on Homelessness and Mental Illness, 3, citing studies by Roth et al. in Ohio (1985) and Struening in New York (1986).
5. *Actions for Quality Care*, Report of the Governor's Special Commission on Consolidation of Health and Human Services Institutional Facilities, Executive Summary, June 1991, 8. Hereafter cited as *Commission Report*.
6. Between 1980 and 1988, the federal budget authority for needed low-income housing dropped from \$27.9 billion to \$9.7 billion. *The Closing Door*, National Coalition for the Homeless, December 1990.
7. See Sarah Glazer, *The Mentally III*, in *Editorial Research Reports*, February 13, 1987, 72.
8. *Commission Report*, 3.

9. *DMH Comprehensive Mental Health Service Plan, Edition 4.0*, May 1991, 117. Hereafter cited as *Comprehensive Plan*.
10. *Commission Report*, 3.
11. While, pursuant to M.G.L. c. 123 (1988), Massachusetts, in theory has both voluntary (section 10) and involuntary (sections 7, 8, 11, and 12) inpatients, it is the practice of DMH facilities not to accept voluntary patients. Thus, a person is either brought to a facility against his or her will and admitted and retained pursuant to sections 7, 8, and 12, or voluntarily seeks treatment and is admitted pursuant to section 11, on a "conditional voluntary" basis. Under section 11, a person who is unsatisfied with the care is not free to leave, but rather must give the facility three days' written notice of the intention to leave. During this period, the facility may petition a court to have the person committed pursuant to sections 7 and 8. Since the court hearing need not be, and most often is not, scheduled for fourteen days after the DMH request, a person who enters a facility "voluntarily" can be forced to remain for up to seventeen days against his or her will without an opportunity for impartial review.
12. *Commission Report*, 3.
13. *Ibid.*, 33. This arrangement has resulted in a total of fewer than 140 apartments being occupied by clients of DMH and DMR. Fewer than 25 of those apartments are subsidized, which, given the substantial market rents charged by MHFA developments, means that the vast majority of independent-living situations being provided by DMH are going to its wealthier clients. MHFA market-rent apartments are not a financially viable option for the homeless, even if they could get accepted for occupancy at such developments. See note 22.
14. *Comprehensive Plan*, 119.
15. *Ibid.*
16. *Ibid.*
17. As a further reflection of the fact that such programs are not really housing in any meaningful sense, DMH, and unfortunately some courts, take the position that people living in DMH residential settings are not entitled to the protection of Massachusetts landlord-tenant law before they can be removed from a program.
18. Only one of DMH's fifteen adult inpatient facilities has been able to meet the HCFA/JCAHO minimum standards for accreditation. *Commission Report*, 5, 6.
19. It must be stressed that these placements will serve only current inpatients. The approximately 4,000 community placements that will exist after adding these 700 new ones will meet only one third of DMH's perceived overall need. *Commission Report*, 28.
20. The cost of community placements ranges between \$30,000 and \$70,000 per person per year, with an average cost of \$55,000. *Commission Report*, 29.
21. *Comprehensive Plan*, 114-15.
22. Even DMH's major effort to arrange truly independent, albeit expensive, living situations, that is, the agreement with MHFA for access to 3 percent of its units built since 1979, is not as expeditious as it may appear to be. The final decision regarding whether to accept a person as a tenant rests with the management of the MHFA development, not with DMH. While DMH often attempts to facilitate acceptance, MHFA developments are, in my experience and that of others who attempt to house the homeless, among the most demanding and least flexible in their tenant selection practices. This fact has two negative effects. First, it induces DMH to seek to house only its "most worthy" (read compliant) clients. Second, the extensive verifications required by the developments again slow down the process of housing those who need a place to stay.
23. Pursuant to 104 C.M.R. section 16.03(2)(c), anyone admitted to a DMH inpatient facility under M.G.L. c. 123, sections 10, 11, or 12 "shall be eligible for . . . an ISP." The goals of the ISP process are set forth at 104 C.M.R. section 16.01(2).

24. *Williams et al. v. Forsberg et al.*, Civ. No. 91-3835E (Superior Ct., Suffolk Co.), and *J.S. and D.M. v. Weld et al.*, Civ. No. 90-7275F (Superior Ct., Suffolk Co.). In the *Williams* case, the plaintiffs claim that DMH's discharge practices constitute the ongoing common law tort of negligent discharge, and that, based on that and several other statutory and constitutional theories, DMH should be ordered to provide the type of subsidy program suggested later in this article.
25. Americans with Disabilities Act of 1990 (ADA), P.L. 101-336, 104 Stat. 327, July 26, 1990. Section 2(a)(8) of the Act provides that "the Nation's proper goals regarding individuals with disabilities are to assure equality of opportunity, full participation, independent living, and economic self-sufficiency for such individuals." People with mental disabilities are specifically included in the coverage of the act by section 3(2)(A).
26. The ADA sections that govern the provision of government services, including mental health services, took effect on January 27, 1992. The legislative history of the act makes it clear that Congress intends services to be provided in the most integrated setting possible, even if doing so is either logistically or financially less convenient for the provider. H.R. Rep. No. 485(III), 101st Cong., 2d Sess. 50 (1990).
27. *Homelessness Needs Assessment*, Executive Summary, 130.
28. While the housing assistance provided by DMH must be reserved exclusively for the mentally disabled, the actual housing acquired with that assistance should to the greatest extent possible be in normal, integrated settings open to all members of the general public.
29. Since DMH and its doctors believe themselves capable of defining and recognizing mental illness, a major problem in operating a general housing program is thereby overcome. In seeking to assist the general homeless population through various housing initiatives, Massachusetts has felt constrained to develop elaborate and often bizarre definitions of the "worthy" homeless in order to protect itself from what it believes would otherwise be an epidemic of voluntarily induced homelessness endured solely to gain access to affordable housing. It is highly unlikely that, even for the substantial benefit of affordable housing, someone would voluntarily seek the stigma still associated with mental illness. Even a person who might do so would presumably not be able to fool a DMH doctor. Hence, quality control should not be a significant problem in the proposed program. See note 19 for DMH's estimate of the maximum number of people who might qualify for such a program.
30. In the Section 8 program, a certificate is valid for no more than four months. If a person is unable to find a qualifying apartment within that period, the person's right to a subsidy expires and the certificate is given to the next person on the waiting list. There would be no purpose for such a time limit in the program run by DMH. Unlike the Section 8 program, the number of eligible people is relatively small and a subsidy would be offered to everyone who needed one. Thus, there would be no need to pass the subsidy along if it were not converted into an apartment within a fixed period of time.
31. While the barriers to housing the mentally disabled are all too well known, the routes around or through those barriers are a relatively well-kept secret. For example, most people, including many DMH case managers and a significant number of local housing authorities, do not realize or acknowledge that mentally disabled persons are eligible for so-called elderly housing developments or categorically eligible for almost all federal subsidies. Nor is it widely recognized that the superficially neutral determination of whether an applicant is "capable of independent living" is in fact an illegal and therefore impermissible inquiry into the nature and extent of a person's disability. While the list of legal solutions to acquiring housing for the disabled is too lengthy to be catalogued here, the point is that housing search workers can be trained to recognize illegal procedures and respond to them. Once they have mastered the field, they will become familiar with housing opportunities for the disabled that are not necessarily available to other members of the general public.
32. To borrow a phrase from the Vermont Center for Community Change through Housing and Support, a pioneering organization in the sorts of solutions suggested in this article.
33. Statement of Dick Gelman, Bronx, New York, May 29, 1991, at the Ninth National CSP Learning Community Conference in Washington, D.C.

34. See a newsletter of the center, *In Community*, 1, no. 1, (June 1991): 6.
35. Exactly how much the proposed model would cost in the long run is largely an unknown, because the calculus depends on many policy decisions that would be made along the way concerning the nature and quality of supports. The center study discussed in the text found that as the severity of the impairments being accommodated increased, so did the cost of providing such accommodation. This model could be made to cost as much as the one now used by DMH, but it would provide more complete and effective services. The center therefore suggests that the supported model may not always be less expensive, but it will never be more expensive for any given level of care. In all cases, moreover, because of the underlying human assumptions of the model, it will provide *better* care for each dollar expended.
36. The median FMR for a studio apartment in Massachusetts is \$465, while that for a one bedroom is \$561. Representing DMH's maximum liability per person, this would almost always be reduced by one or both of the following factors. First, the tenant would contribute 30 percent of his or her income toward the cost of the apartment. If the person were receiving, for example, SSI at the current rate of \$520 per month, the tenant share of approximately \$160 per month would reduce the cost to DMH, even based on the full median FMR, to \$400 per month. However, especially in a soft market, apartments are almost always available for less than the FMR in any particular area. While the 1990 one-bedroom FMR for Medford, a city within five miles of Boston, was \$739, the actual average rent of all the Section 8 one-bedroom apartments administered by the Medford Housing Authority that year was just under \$510 per month. When the predictable tenant share is deducted from this figure, the cost to DMH is even less than that cited in the text.
37. Judging from late 1991 newspaper articles and so-called think pieces, it is becoming increasingly popular to blame the homeless for their condition. Presumably this phenomenon reflects the traditionally short attention span and low frustration threshold of the American public, which, after unsuccessfully throwing very little money and even less thought at a problem, is more than willing to blame a victim for his or her own fate. The in-vogue argument along these lines points to the mentally disabled homeless and suggests that those who think the problem is housing "just don't get it." In fact, the problem *is* housing, or at least affordable housing, which is an enormously scarce resource. While a person's mental disability may help explain why she in particular is homeless if she has been asked to compete in the open market for that resource, it is no indication that she cannot live in a community if reasonable accommodation is made for his or her handicap. A subsidized housing program exclusively for those with mental disabilities is just such an accommodation.
38. Statements of Grace Lewis, state housing coordinator, Ohio DMH, and Robert Myers, director of local operations and community capital, New York Office of Mental Health, delivered May 30, 1991, at the Ninth National CSP Learning Community Conference in Washington, D.C.

Massachusetts at the Crossroads

Richard E. Ring

Massachusetts is at a critical juncture in its care for homeless individuals. In the face of a charged political climate and with a governor bent on the "downsizing" and "privatization" of government services, decisions are being made that are of major importance to the welfare of homeless individuals in this state. Based on the choices of the state administration, Massachusetts can either solve its homelessness problem in the near future or relegate its homeless population to a lifetime spent on the streets or in shelters. In comparison to other states, Massachusetts has been relatively successful in caring for homeless people. The foundation for this success rests with a broad-based coalition of people from all walks of life united by a genuine desire to help people in obvious need. This coalition serves as a constituency for homeless people, a large and generous source of voluntarism and financial support, and as a political force of its own. Ring provides a brief history of homelessness in the Boston area as well as his own prescription for solving the problem.

Massachusetts has reached the turning point in its care for homeless people. It can either build upon the caring traditions and enormous effort of the past twenty years and actually begin to solve its homelessness problem, or it can slide back into a situation in which the number of homeless people once again increases and the only substantial response is to expand emergency shelter — a response that salves our collective conscience but does little to help people move out of homelessness.

Massachusetts, among all the states in the entire country, holds the greatest promise of ending homelessness. The winter of 1990–1991 was the first time in nearly twenty years that there was an adequate supply of year-round shelter beds for single men and women.¹ Adequate capacity, however, was a tenuous proposition that winter, but I can state with a fair degree of confidence that in Massachusetts and its capital city of Boston there has been, at the very least, shelter and other emergency services available for all those in need. This is a critical precedent to have established. Homeless people and those who work with them locally are not only poised to move "beyond shelter" but will

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suffer a tremendous sense of futility and outrage if the solutions to this problem — solutions that are no mysteries — are not forthcoming.

In fact, there is no reason why homelessness cannot be ended in this state over the next few years. The solutions, some of which have already been implemented in modest ways, lie in a four-point plan that includes prevention, emergency shelter and related services, transitional housing and job programs, and permanent, affordable housing. It is important in this equation not to underestimate the value and need of emergency shelters, as they are the first line of refuge and, realistically, the unfortunate truth is that some people are not going to lift themselves out of homelessness. Emergency shelters, which are run with great care and compassion in this state, must exist in ample supply as a safeguard against death on the streets. But the majority of homeless people have the ability to regain partial or complete independence, lead productive lives, and contribute once again to society. For the benefit of everyone, there must be a conversion of resources that will place greater emphasis on programs to lead people out of homelessness.

Is this foolishness? Have I been so close to this scene for too many years that I naively think we can end this phenomenon? Perhaps. But my optimism stems from the fact that no other state has addressed this issue as directly as Massachusetts, nor has any other state the foundation in place to complete the job. Current statistics place the number of homeless people in Boston at 4,000; statewide the number is more controversial but ranges from 15,000 to 25,000. Local government got involved in a major way for the first time in 1983, when then Governor Michael Dukakis pledged that care for homeless people would be his number one human service priority. One year later, Raymond Flynn was elected mayor of Boston and adopted an equally committed position, which he holds to this day. But even for many years before that, private agencies and volunteers had embraced the cause of street people and created caring programs that were philosophically steeped in respect for each homeless person as an individual. As such, for nearly twenty-five years this group has embodied a broad-based, loosely connected, cooperative coalition that has brought love and care to homeless people.

Much of the real success of Massachusetts in addressing the issue of homelessness lies in the commitment, perseverance, and collective effort of this coalition. As a rule, it issues no press releases, does not stage demonstrations, or use the confrontational tactics we usually associate with "coalitions," although from time to time each of these devices has been used effectively by homeless people, shelters, and advocacy groups. This broad-based coalition has been, in essence, a movement grounded in heartfelt conviction, consisting of citizens who have volunteered to feed, shelter, offer medical care for the homeless, and contribute financially to homeless programs all over the state. This coalition includes idealistic men and women who work as staff in shelters, housing programs, and advocacy groups, city and state workers who have successfully managed public programs, and elected officials who have enacted creative and supportive legislation to address the problem.

The key to our dealing as a citizenry with the issue of homelessness is precisely that many members of our commonwealth, believing this to be a pressing social issue, have given of their time, their talents, and their treasure to help their brothers and sisters. Some are motivated by religious beliefs, following literally the words of Matthew: "For I was hungry and you gave me food; I was thirsty and you gave me drink; I was a stranger and you made me welcome; naked and you clothed me, sick

and you visited me.”²² Others are motivated by a sense of responsibility for those in need and still others by a desire that government respond to the needy. Whatever the motivations, we essentially have succeeded in the first objective — almost all men and women who need it have shelter available to them.

Recent History

As recently as the 1960s a homeless person was thought of as a skid row alcoholic: male, white, and over forty-five. The numbers then were much smaller than today, and there were few homeless women on the streets. The primary caretakers were private agencies like the Saint Vincent de Paul Society and the Salvation Army. Because alcoholism was the dominant problem and (until 1973) public drunkenness was still a crime, municipal hospitals and police departments were often the first and only line of assistance. In Boston this was particularly the case with Boston City Hospital and the Boston Police Department. In addition, the court system routinely sentenced chronic alcoholics to the Massachusetts Correctional Facility at Bridgewater for thirty or sixty days to “dry out” or, sometimes in a humanitarian gesture, stretched the sentence out for 180 days — long enough for someone to “winter over” and thereby survive our harsh New England winters. Over four hundred “transients” would stay at Bridgewater, while many others would voluntarily choose to go to the state public health hospital at Tewksbury.

In the late 1960s, several events occurred that altered and improved conditions; they provide early indicators of the coalition that endures to this day. Agencies like the Pine Street Inn, Haley House, and Hope House were organized with a mission to improve the lot of the street alcoholic. Volunteers from all walks of life began working through these agencies; they were equally intent on offering a warm smile and an encouraging handshake along with the hot soup, sandwiches, and winter coats they brought along. It is of no small political consequence that after all these years, the thousands of people who have had firsthand volunteer experience in shelters make up a formidable constituency in support of homeless programs. In addition to this, beginning in 1973 the public alcoholism policy shifted from punishment to rehabilitation. In essence, a caring and enlightened group consciousness began to evolve; over time, that enlightenment was translated by a sympathetic state legislature, led most notably by Senate president William Bulger, into publicly funded programs.

The first significant threat to this situation occurred in the mid-1970s as the presence of deinstitutionalized mentally ill persons began to be seen throughout the commonwealth. At that time, the Department of Mental Health (DMH) reduced its inpatient census 90 percent, from 25,000 to 2,500, with the promise that a state-of-the-art system of community-based care would be established. The new system would rely heavily on the use of psychotropic medications, outpatient clinics, and community based homes. Although deinstitutionalization worked for the lucky few, it has been an unmitigated disaster for the thousands who have ended up on the streets or those who comprise 50 percent of the shelter population. The specter of deinstitutionalization gone awry hovers over our state, as we still see in every urban center the mentally ill eating out of dumpsters, sleeping on heating grates, unkempt, neglected by the public mental health system — seen sometimes as screaming wildly at no one, screaming wildly at everyone, and sometimes putting an end to their tortured lives.

Then in the 1980s the floodgates opened. The number of homeless soared as the federal government quickly reduced its commitment to domestic programs at the same time as the cost of housing, especially in the Northeast, rose dramatically. The number of people without a place to live increased to the highest level since the Great Depression, including a new class of homeless: men, women, and children who were simply poor, people without any discernible physical or emotional disability, the uneducated, those with no job skills, drug addicts, and people with AIDS. A mix of social ills had developed which at one time would have been confronted by the War on Poverty but were now all conveniently being lumped together under the catchall phrase of homelessness. Shelters, traditionally the first line of defense, were being called on to forge a whole new system for the delivery of social services to the poor.

Because there consistently had been a good-faith effort by our own home-grown coalition, the citizens of this state were spared the indignities visited on other cities. In Massachusetts there have not been legions of homeless people wandering about on our streets or, like New York City, huddled in major transportation terminals or living underground in the transit system. Boston, unlike Los Angeles, does not have 35,000 homeless people. Boston, unlike Miami, is not just now trying to care for the 6,000 homeless people it has officially and purposely neglected for years, hoping the "problem" would go away on its own. In the Bay State there has been a true public/private partnership, bringing us to the point where homelessness finally can be solved — or it can all unravel.

A Prescription for Solving Homelessness

To be precise, in my view we should do the following to end homelessness:

1. The place to start is the Department of Mental Health. It should be turned upside down in a reorganization that would finally respond to the homeless mentally ill. Basic human compassion calls for this. At the risk of sounding self-righteous, I believe this should be done strictly on moral grounds as the mentally ill and children are the two most vulnerable groups among all who are homeless. (In December, 1990 a class-action lawsuit was filed in the state Superior Court against the state on behalf of homeless persons, with Mayor Raymond Flynn, Pine Street Inn, and psychiatric nurse Rand Bailey — later joined by other advocates — constituting plaintiff class. The case is still pending.)³

A fear of shelter providers is that privatization of mental health services, as proposed by the William Weld administration, offers no guarantees of improvement. There remains a major question: Will private hospitals have the commitment — the will — to care for the homeless mentally ill who generally require more patience on the part of the provider? Or will private hospitals deal only with more treatment-compliant patients and leave the homeless mentally ill untouched on the streets?

2. The Department of Public Health detoxification units and clinics for alcoholics and drug addicts should be improved. Why? Beyond the obvious humanitarian reasons, these people not only have the capacity to remove themselves from dependency on shelters and the public health system, but once recovered they again become contributing members of society.

3. Housing and hospice care should be provided for people with AIDS. Homelessness becomes the inevitable consequence for many HIV-infected people who lose the ability to work, and maintain income and housing. This is a growing problem.

4. As many emergency shelter beds as possible (that is, twelve to eighteen a month) should be converted into transitional housing and economic development programs, which are closely connected to additional permanent affordable housing and permanent jobs that actually go to homeless people. This is an important point. There is no resistance on the part of established shelters toward this concept as long as adequate emergency services remain. Pine Street Inn is a good example. As recently as three years ago, the Inn sheltered 1,000 men and women on any given night. Pine Street has now evolved into more of a multiservice facility, and while it still serves 1,000 people daily, 650 are in shelters, 150 are in transitional programs, and 200 have permanent lodging house rooms in the Pine Street Inn / Paul Sullivan Housing. In addition, the Inn now cares for children.

5. The use of tax credits, public grants, low interest loans, and rental subsidies should be continued to maintain and develop new lodging houses to provide enough permanent affordable housing for all in need. But housing in and of itself is not enough. It must be housing with supportive services to have lasting success.

6. Job training should be put in place and jobs should be created that actually extend far enough to affect homeless people. Like many other social programs, current job training programs are geared for people in need who also may happen to be easier to work with, and therefore provide more "success stories" than homeless people do. The key to understanding homeless people is that they do not become homeless overnight. There are reasons. Often their decline follows a slow, cold, downward spiral. Programs that help should give enough time to allow people to regain their hope, trust, and self-esteem.

Whose Responsibility Is It?

Our present economic difficulties both nationally and locally are causing us to hesitate, to think we need to draw back from such commitments of money and other resources for homeless people. The financial constraints and pressures of the past two years have led us to "downsizing" and "privatizing" publicly funded programs when at the same time we see the possibility for many to move beyond shelter. The coalition, the network of homeless people and their supporters, never saw "warehousing" people as their chief objective. They never wanted to hide homeless people from the eyes of those who pass and drive by. No. They possessed the hope that there is a way back, a step up the ladder to a full life. We cannot let the present fiscal problems deter us from this goal.

So whose responsibility is it?

In one sense, it is up to all of us — you, me, "society," and homeless people themselves. Yet the coalition I have described has been working and building programs for nearly twenty-five years and can no longer act alone. While I see no lessening of its effort or signs of "compassion fatigue," the magnitude of the problem calls for strong government action.

Nationally the federal government is responsible, but in reality has done very little. Sadly, President Ronald Reagan told the country that people "choose" to be homeless, and although George Bush has promised a kinder and gentler nation, he presides over a country that has become poorer and meaner in spirit, one in which homeless people have become convenient scapegoats. Although Congress enacted the Stewart McKinney Act,⁴ which is the only substantive federal initiative to curb

homelessness, there are still too few dollars appropriated for a problem that continues to grow across the country. Only the late homeless advocate Mitch Snyder was able to keep the nation's attention focused, and since his death, official Washington largely has been indifferent to the issue.

Massachusetts governor William Weld has the perfect opportunity to align his administration's actions toward homeless people with some of his stated philosophical beliefs. He wants government to become creative and cost-effective in an entrepreneurial sense, and he also wants individuals to assume full responsibility for themselves. At this time and in this political climate, his leadership on behalf of homeless people is absolutely essential, as the burden of responsibility falls squarely on his shoulders. He has promised financial solvency for the commonwealth and has set out upon that task with a passion. Although he also has promised compassionate care for the poor and needy, to date his actions, both symbolic and real, send a mixed message. He needlessly offended many by asserting that he wants the social service safety net to become a "trampoline, not a hammock." This is pretty tough talk about a future goal that both the governor and most of the poor and homeless share: an opportunity to achieve self-sufficiency. Weld's budget cuts in mental health, public health, welfare, and housing began to rip apart the very safety net he spoke of because shelters, in an unfortunate but predictable reversal to former days, became overcrowded.

Within shelters, the prospect of losing control increased every day. Potential tragedies loomed ahead and the Weld administration risked the public perception of being callously indifferent to homeless people. However, the governor responded. At a press conference in January with such advocacy groups as the Greater Boston Adult Shelter Alliance, Massachusetts Community Action Programs, and the Massachusetts Shelter Providers Association, the governor pledged his commitment to address the issue in a varied and enlightened way. He promised to seek remedies that would be preventative and both short term and long term in nature. At that time, he said he would support and increase funds for the arrearages program, a prevention plan that helps with delinquent rent, mortgages, and utilities. He also pledged to increase current shelter capacity by 160 beds and promised to fund 91 transitional apartments, additional alcohol and drug detoxification beds, and new group homes for the mentally ill. In all, the governor intended to increase preventative programs while adding an array of nearly 400 new beds for homeless people.

This was a beginning, a hopeful sign that he wants his administration to be entrepreneurial with respect to homeless people and that he wants to invest resources in the types of programs that will ultimately reduce the homeless population in this state. This is a much needed and important promise from the Corner Office. Accompanying this promise is the understanding that supportive services and housing, not merely more emergency shelters, is the route out of homelessness. Keeping in mind that a promise and reality are not necessarily the same thing, the governor and his staff must monitor the situation closely to ensure the successful delivery of services.

Why am I singling out the governor? What about Mayor Raymond Flynn and the legislature? The answer is that Boston serves homeless people from all across the state and uses every available dollar for shelter and housing, while the politics of the day, hostile toward the established government institutions, have given the edge to the governor over the legislature. Governor Weld inherited a homelessness situation

that was under control and beginning to move people beyond shelter. This is the year the incumbent governor will take ownership of the problem of homelessness. I am not denying that these are difficult financial days for the commonwealth, but there remains the tradition and expectation that while the chief executive balances the state's books, he does so with compassion for the poor. The situation in Massachusetts is manageable. The coalition has seen to that. Homeless people want to be off the streets, and those who work with them know what to do. Meeting the challenge of whether or not we solve this problem over the next year or two or keep homeless people as a permanent part of our landscape rests with the future policies and actions of Governor Weld.

A Movement of Practical Idealists

In closing, let me be a little philosophical.

This coalition of citizens that developed around the homelessness issue represents a cross section of political opinions. It runs from radical left to radical right, from left-wing Democrats to right-wing Republicans, from bleeding hearts to hard hats. I know this to be true since my position at Pine Street has allowed me to listen, talk, and work with people all along this political spectrum.

The political positions within this coalition are secondary to this issue. What I believe everyone has in common, regardless of political position, has been the genuine desire to help homeless people help themselves. This coalition has not expected government to solve the problem itself, but to solve it by working together in a true public/private partnership. And more than that, what I see in the members of this coalition is the growing realization that self-help and interdependence by homeless people is crucial to the formula. By this I mean that the fundamental issue underneath it all — homelessness, deinstitutionalization, hunger, drugs, and so forth — is the dignity of the human person. If a person's dignity is not nurtured, then all the programs, funding, and good works are for naught.

I hope that with Governor Weld's help, this coalition of citizens will encourage us once again to focus on the possibility of self-help, interdependence, and cooperation so as to allow our homeless friends to move ahead with transitional housing, permanent housing, and job opportunities.

Notes

1. In 1990–1991 there were approximately 2,339 state-supported beds available. In addition, the Department of Welfare subsidized 572 apartments for homeless families, housing an average of three people per family.
2. Matthew 25:35–36.
3. The case was filed in Suffolk Superior Court as *J.S. and D.M., individually and on behalf of all persons similarly situated, by their next friends Rand W. Bailey, R.N., Pine Street Inn, Inc., and Raymond L. Flynn, as Mayor of the City of Boston v. Governor of the Commonwealth of Massachusetts, Secretary of Human Services of the Commonwealth of Massachusetts, and Commissioner of Mental Health of the Commonwealth of Massachusetts*, CA No. 90-7275F.
4. The Stewart B. McKinney Homeless Assistance Act was passed in July 1986.

Streets Are for Nobody: Mary

Early fifties; married, with one child. Employed when homeless 1970–1972. Works in a shelter.

I had left home because of an argument. And I couldn't afford an apartment, so, um, I had got a room up on Temple Street in backa the State House. And, ah, the landlady there had a little bit of a problem — she used to think that the men that lived in the house were trying to get into bed with her every night, so she'd be knockin' on my door, "Help me! Help me!" So I just couldn't take her anymore, so I just left and, ah, stayed on the street, you know, knew everybody — we all stayed up on the hill. I'm the only one that had a job, so I used to feed everybody. Payday would come and I would go shopping. We'd have picnics up on the hill — up on the Boston Common. On weekends in the summertime, we'd all come down here fishin' and barbecue down here and spend the whole weekend. And then I'd leave about midnight, time to go somewhere and get some rest to get up the next day and go to work. I worked in a printing company.

We knew a lotta people that had rooms and stuff, so we'd just go there, take a shower and clean up. And every week I'd do my laundry for the week and I'd put it like in a little bag, and then I would go to the Jordan Marsh ladies' room and change, you know, and do my things in the sink in the morning — wash up and comb my hair and everything, put on my makeup for the day, and go out.

I was totally happy. Well, I thought I was happy because I was going out with somebody at the time and I thought we were gonna get married. I didn't know that he was not a very nice-type person. I saw him about two weeks ago — filthy, dirty, in the gutter, you know. I just practically stepped over him. But anyway, it was — it was a good experience. That's why I know a lotta these people that come in, not the younger ones, but the older ones — we used to all sleep together on one blanket. From seventy to seventy-two.

And I used to work [nine to five]. At night when I got outa my job, around nine o'clock at night, I used to go help out in a, um, a restaurant on Charles Street.

I probably . . . probably wouldn't do it again. Even if I was the same age, I don't think I . . . I'd do it again. First of all, the summer it was nice because we'd be, you know, out at the beach all the time. But in the winter, I just can't hack it, and how much can you stand on a grate to keep warm, you know? It's dangerous, for one thing, you know, and then you have to watch out at night when you sleep for the rats

Interviewed by Melissa Shook, June 24, 1990, Castle Island, South Boston. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

and whatever else. So, mosta the time, we just stood up all night. I used to be at work in the ladies' room a lot, catchin' forty winks [laugh].

Well, when I was homeless, most of the people that were homeless were either alcoholics or just young runaways. There weren't that many people that had, you know, come outa mental institutions and stuff.

There was a woman named Helen that lived in, um, the Park Street subway station. She had a locker and she'd keep all her clothes and her cat in there. She used to carry her cat around in a bag, shoppin' bag — and then put it in there at night. She had a beautiful singin' voice, she could sing. And I heard she passed away, um, couple a years ago. And she used to dress fit to kill. She was always a . . . fashion plate, you know, with the makeup and everything.

[A better social net would be:]

A shelter with ss . . . s . . . some limits, some goals for the women, not to open up more shelters — that's not the answer. The answer is affordable housing for people. Granted a lot of these people have mental problems, *but*, open up supervised housing. Some of these people could function very well.

I own my own home, okay, and I have tenants. I cannot go up on their rent because I feel sorry for people. Meanwhile, that means I have to put out of my pocket "x" amounta dollars so that I can cover my mortgage every month, because people have to live somewhere. And when I had apartments for rent, I told the real estate agent, do not send me anybody unless they have children — nobody wants to rent to people with children. So I shoulda went up on my tenants' rent three years ago. I can't do it. They can't afford it, so what am I gonna do? Throw them out on the street? 🐼

Private-Sector Funders

Their Role in Homelessness Projects

Nancy Roob
Ruth McCambridge

As the problem of homelessness escalates, private funders struggle to define the most appropriate role they should play in addressing one of our nation's most pressing and visible social problems. Through surveying and compiling the opinions of Massachusetts funders, this report documents funding trends in homelessness throughout the state. By examining government policies and spending patterns, the report attempts to place these trends in context. The analysis and the questions that conclude this report are designed to help develop an appropriate future role for funders in addressing this problem.

The Private Sector's Response: Setting a Theoretical Context

As a way of determining private-sector funding responses to the problem of homelessness, the Fund for the Homeless surveyed sixty-seven Massachusetts funders.¹ The survey, which covers the years 1989–1990, revealed four approaches private funders are taking to address the problem. All data pertain to the two-year period of the survey.

1. The relief of immediate need, which includes shelters and related emergency programs. Fifty-nine percent of the funders support homeless shelters, and more than half of these increased spending in this area.

2. The support of “rehabilitative” programs, which focus on the diagnosis and recovery of the individual, often through residence in a transitional housing program. This may include, for instance, the widespread use of “housing dependent on services”² models; 62 percent make grants toward transitional housing. Grants in this area have increased.

3. The support of permanent housing development projects; 56 percent support affordable housing initiatives. Overall, funding in this area has remained fairly level.

4. The support of public policy development, organizing, and advocacy aimed at increasing the availability of decent and affordable housing and adequate income

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assurances; 28 percent support public policy research and advocacy. On average, funding in this area has remained fairly level.

Only 22 percent of respondents fund advocacy around income issues. This category includes support for organizations concerned with adequate welfare and income benefits. Over half of the respondents providing funding in this area reported having decreased spending in this area.

Theoretical Perspectives on the Problem of Homelessness

The different approaches to addressing the problem of homelessness are loosely founded in three distinct sets of assumptions about poverty and the poor in this country.

The Static Perspective. The first approach is premised on the belief that the poor will always be with us, needing our charity, and that homelessness is simply a by-product of poverty at this particular time in social history. This static perspective places little emphasis on the systemic causes of poverty and homelessness, and its proponents take no active responsibility for causal factors. This concept is a holdover from colonial Protestant theology:

Religion defined the presence of poverty in the world as natural and just, and its relief as necessary and appropriate . . . At the root of the religious position was the premise that the existing social order had divine approbation, that its form was not accidental or fortuitous, but providential. A higher design made some men rich, eminent, and powerful and others low, mean, and in subjection.³

Typical responses to the problem take the shape of emergency and basic services, including shelter, soup kitchens and “quick-fix” preventative methods (the infusion of emergency funds and resources when eviction is imminent). While these services are necessary, they tend to move people beyond an immediate crisis or treat their suffering in the midst of the crisis but do not always relieve the conditions that caused the crisis.

The Attributive Approach. A second theoretical approach ascribes the problem of homelessness to the pathologies of individuals. In its most extreme form, this approach maintains that people have caused their own luck and have brought about their own poverty through incompetence and/or moral or mental failing. Imbedded in what we refer to as the attribution model is the notion that there exists an ever increasing block of impaired or undeserving poor. This is reflected in the language of culture of poverty and other academic approaches that segregate certain poor people from the rest of society and place them in a permanent, inescapable underclass.

Over two centuries, a U.S. mythology supportive of a free-market economy has developed. This belief system, now firmly ensconced in popular culture, includes the “classless” notion that anyone with a little initiative and a lot of hard work can make it in this country. Therefore, when millions begin to fail in so profound a way as to be reduced to sleeping in streets and shelters, they must either be held blameless through some infirmity or responsible through a weakness of character. Either way, they are clearly in need of rehabilitative work. Within this construct, homelessness is, at least in good part, attributed to various conditions like mental illness, developmental disabilities, substance abuse, or simple laziness.

Exhaustive attempts to research the deficits of homeless people, diagnose, and then treat them clinically grow out of this attribution model. Funding responses that follow from this analysis may briefly acknowledge housing and economic causes but are primarily conceived within the structure of a medical or social work model that includes specialized treatment programs.

The Systemic Analysis. A third model assumes a systemic approach rooted primarily in economic factors, including housing affordability and income. Manifestations of trauma, including substance abuse, may be present, but homelessness itself is not attributed to internal individual defects. In this model, responses to the problem include attempts to increase access to and retain affordable housing and adequate income. Included in this might be grants made to support low-income housing development directly, but the response that acknowledges the scale of this problem includes public policy analysis and advocacy.

How Funders Respond

More funders assume the first and second approaches, paralleling the public sector's response to the problem, which includes relief of immediate need or a rehabilitative approach to the individual. A close third is permanent low-income housing development, with the systemic response following as a poor fourth.

These private-sector responses are extensions of assumptions about the causes of homelessness. However, as one's understanding of root causes changes, so might one's funding response. As we will see later, funders in the private sector are concerned about prevention but uncommitted in many cases to a particular preventive strategy.

Before we look at private funders' responses, however, we will attempt to set a backdrop by briefly examining government approaches to the problem of homelessness.

Trends in Government Funding of Homelessness

The private sector's funding response to the problem of homelessness can be partially understood as an attempt to fill the gaping holes left by an inadequate government response. It is the belief of many analysts in the field that homelessness is one aspect of growing inequities between the moneyed and the poor during a period of rapid and profound structural changes in the economy. This is necessarily an extremely difficult issue for the federal government to come to terms with. On the one hand, in its very nature, homelessness is starkly obvious and evocative. Whether it elicits responses of pity, outrage, or annoyance on the part of Americans, homelessness is viewed as a very real problem. On the other hand, addressing the very basic economic issues involved would be a radical departure for both state and federal governments.

Most of our elected officials do not acknowledge the importance of adequate income assurances for the poor and insist on the self-adjusting mechanisms of a free-market economy even when basic human needs remain unmet for extended periods of time. Avoidance of these central economic issues has led government to approach homelessness in either a static or attributive fashion, in the former case, viewing the problem as in need of crises intervention in a short-term mode or, in the latter, attributing the problem to various individual dysfunctions.

In his article "Neutralizing Homelessness," Peter Marcuse states, "Homelessness poses U.S. policy makers with a critical dilemma: they cannot actually solve the problem of homelessness in the U.S. and yet they cannot ignore it or conceal it either."⁴

As a result, the public sector has chosen to fund a confusing array of shelter programs, related emergency service responses, and more recently, "transitional" programs, which presuppose an inability to remain in housing without provision of services. Even were we to view this confusion as a case of benign mismanagement, if systems thinkers are to be believed, "management teams typically come unglued when confronted with core dilemmas." As a result, standard avoidance techniques can be identified. The particular brand of (mis)management seemingly at work here is described as "shifting the burden." In an article in the fall 1990 edition of the *Sloan Management Review*, Peter M. Senge outlines this phenomenon as follows:

A short-term "solution" is used to correct a problem, with seemingly happy immediate results. As this correction is used more and more, fundamental long-term corrective measures are used less. Over time, the mechanisms of the fundamental solution may atrophy or become disabled, leading to even greater reliance on the symptomatic solution.⁵

As we examine the Massachusetts and federal government responses to the problem, we ask you to keep this archetype in mind. Are there more fundamental issues to be confronted than are currently addressed in government programs such as shelter or case management programs?

The Massachusetts Response

Massachusetts had, until 1990, been viewed nationally as having one of the most thoughtful and progressive state response mechanisms for homeless people. It has included a family shelter system delivered through a network of independent, non-profit agencies running small, homelike facilities; funding for individual shelter beds nearly sufficient to meet the emergency shelter needs; and a prevention strategy that has made innovative use of federal dollars not targeted to homelessness but more generally to low-income people. Since approximately a year before Governor Michael Dukakis left office in 1990, these programs have been at risk along with the rest of the human services and housing budgets.

At the center of the Massachusetts response to homelessness is its shelter system, which grew from three to more than one hundred state-funded facilities over a period of seven years, from 1983 to 1990. But what most distinguished Massachusetts from other states was its commitment to prevention. Even this has its limitations, however.

An analysis of what the state considers to be homelessness-related funding, as reflected in its 1990-1991 Comprehensive Homeless Assistance Plan (CHAP),⁶ shows that a significant portion of what is termed "preventive spending" has been allocated through the Emergency Assistance (EA) program. An examination of the provisions of this strategy shows it to be of the short-term type, designed to ward off immediate crisis, but not to change the overall causal conditions. The EA program actually preceded widespread homelessness, allowing eligible families facing emergencies to qualify for one-time benefits no more often than once a year. These benefits include rent or utility arrearages, moving expenses, and other necessary costs to meet the emergencies of actual or imminent homelessness.

As housing costs skyrocketed in the eighties and the costs of renting began to far exceed the dollar amount of Aid to Families with Dependent Children (AFDC) grants, the EA program became increasingly essential to the survival of families not living in subsidized housing. In Massachusetts we are on the extreme end of the scale because of our high housing costs but, in fact, an AFDC grant for a family of three is insufficient to pay fair market rent in all but eight states. (See Figure 1.) In Massachusetts, the entire monthly AFDC grant for a family of three covers only 69 percent of the average rent and utilities for a two-bedroom apartment. This includes no other living expenses.

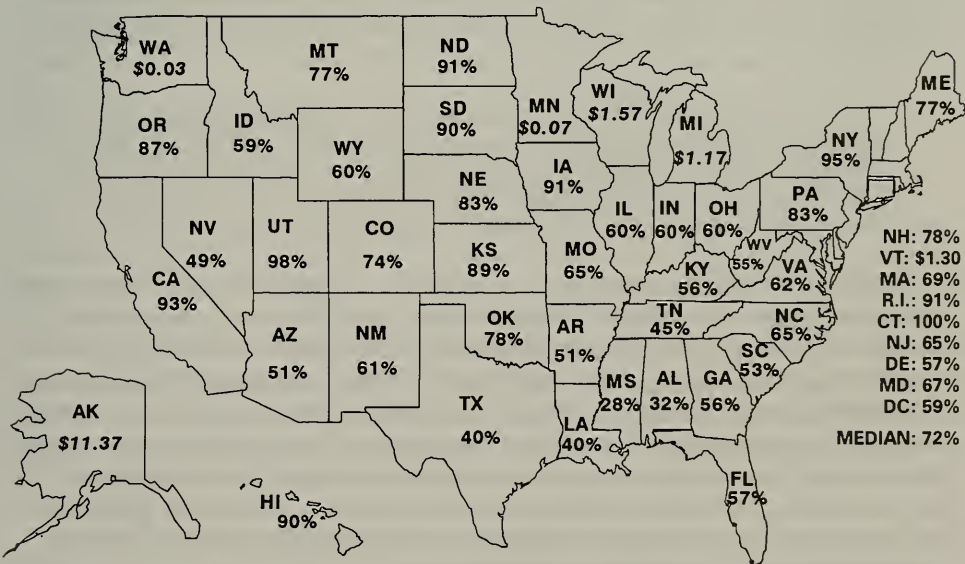
Ever more starkly, Emergency Assistance has become a resource necessary to cover basic and predictable expenses. In other words, benefit recipients were in an unacknowledged but ongoing state of emergency. Thus what is termed a “homelessness prevention strategy” may also be termed a “reality avoidance strategy.”

Figure 2 demonstrates how AFDC grants across the country have decreased in real value since 1970. Nationally, according to a new House Ways and Means Committee report, the purchasing power of AFDC cash benefits received by a three-member household has declined nearly two-fifths over the past two decades.⁷ In Massachusetts, as in most of the country, it costs more than what an AFDC grant can provide to remain housed.

It is therefore not surprising that families have resorted to Emergency Assistance in order to accomplish the impossible task of housing, feeding, and clothing an average of three people on less than \$500 per month.

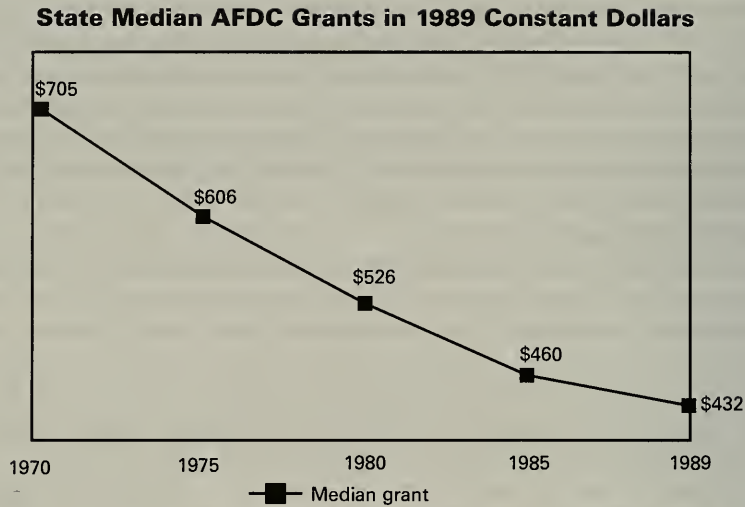
Figure 1

**Percentage of Rent for Two-Bedroom Unit Covered
by Entire Welfare Grant for Three-Person Household,
or Amount per Day for Other Needs, 1991**



Source: National Low Income Housing Coalition and National Coalition for the Homeless. Reprinted with permission.

Figure 2



Source: National Low Income Housing Coalition and National Coalition for the Homeless. Reprinted with permission.

Real housing costs in the Boston Metro area increased by 44.3 percent from 1983 to 1990,⁸ while individual AFDC payments have increased by less than 10 percent during the same period.⁹ (Note that this figure includes a \$40 per month rent subsidy, which only AFDC families living in nonsubsidized housing receive. The real increase for families who do not receive that rent subsidy is closer to one percent over the seven-year period.)

The impact of drastically increased housing costs is not limited to those receiving assistance benefits. As Robert Greenstein, director of the Center on Budget and Policy Priorities, stated before the House Committee on Ways and Means earlier this year,

The average hourly wage for private, nonsupervisory workers is now lower, after adjustment for inflation, than in any year since at least 1969. In addition, the minimum wage — which was sufficient to raise a family of three out of poverty in most of the 1960s and 1970s if a parent worked full-time year round — now leaves a three-person family with a full-time worker \$2,300 below the poverty standard.¹⁰

Working Massachusetts residents must make an hourly wage of \$15 in order to afford a two-bedroom apartment. (See Figure 4.) This is higher than that for any other state. In fact, average hourly income in Massachusetts in 1989 was only \$10.60.¹¹

At this time, the EA program is vital to the out-of-shelter survival of tens of thousands of Massachusetts families and individuals, but its growth has merely delayed a confrontation of the problem of incomes too meager to support basic human needs. It has also created enormous budgets in so-called emergency service categories. Total Emergency Assistance payments increased 754 percent, from \$7.5 million in 1983 to \$64.1 million in 1990, and total payments for emergency shelter increased 1,400 percent, from \$2 million to \$30.1 million.¹²

Still, there is significant value in even short-term housing retention strategies; however, as Massachusetts is faced with an enormous state budget deficit and an

administration unwilling to raise additional taxes, the cutting of programs has focused on those which the state has, in the past, termed preventive. The Emergency Assistance program, the cornerstone of the Massachusetts plan, has been cut in half.

As homelessness became a more obviously persistent aspect of life in the commonwealth, and as the trauma people were experiencing in the midst of increased destitution became more obvious, the state's response began to assume a tone that attributed more fault to homeless and other low-income people for their impoverishment. This has made cuts in emergency services more palatable and possible.

Until these cuts, the Massachusetts contribution to the attribution model had been sophisticated and reflective of an academic and social service orientation. Research that sought to document differences between homeless and other poor families established a body of literature which was cited nationally by proponents of more intensely treatment-oriented programs for homeless families. Although this research is the subject of much skepticism on the part of shelter providers and, in fact, has been refuted in large part by subsequent studies, its spirit and basic assumptions have been picked up in the more clinical program models, including the specialized treatment shelters and transitional housing projects now in fashion.

To be fair, until recently Massachusetts has also been able to boast of one of the most active state housing programs of the past decade. Unfortunately, lack of federal involvement, a growing disparity between incomes of the poor and well-off, and an extraordinarily tight housing market dwarfed the scale and overall effectiveness of those efforts. Although more compassionate and comprehensively organized than most states, the Massachusetts response to homelessness still fell short. Over the years when these programs were most active, the population of homeless people in the state continued to burgeon.

The Federal Response

The federal response to homelessness has been even far more fragmented at its best. From Reagan's now famous comment about homeless people actually wanting the lifestyle of the streets to the persistent undercounting of homeless people in the 1990 census, the federal government has been suffering from a deeper level of denial than Massachusetts.

During the 1981-1982 recession, the media stopped presenting homelessness as a collection of hoboes, bag ladies, and skid row bums and instead began focusing on the real people, the individuals and families who had been caught in the phenomenon. The stories of random circumstance began to take on a repetitive nature. Joblessness and the increasingly evident poverty of households headed by women began to be tabbed as contributing to the problem. Unable to address the need for income assurances for households headed by single women or the problem of growing wage disparities among workers, the administration approached the problem as a temporary symptom of the unemployment of the period. "The new homeless were presumably the working poor and those recently forced into idleness, casualties of widespread economic dislocation reminiscent of the Hooverville inhabitants during the Great Depression."¹³

In 1983, Congress passed an emergency jobs bill, which included appropriation of \$100 million for emergency food and shelter for the homeless.¹⁴ Congress established a national board made up of representatives from the private and public sectors, the Interagency Council on the Homeless.

This unconventional administrative arrangement, relying upon private organizations to distribute federal funds, reflected the belief that homelessness was a temporary consequence of the recession and that existing organizations could distribute the funds effectively and expeditiously through their networks of local chapters and nonprofit organizations that operated most services for the homeless.¹⁵

Even when the recession passed, homelessness not only persisted but escalated. Since 1980, 44 percent of new jobs created in this country were at wages at or well below the poverty level,¹⁶ and during this period federal subsidies for low-income housing continued to drop in relation to need. Benefits levels were not indexed to keep pace with the cost of living, so their real value also continued to decline over these years.

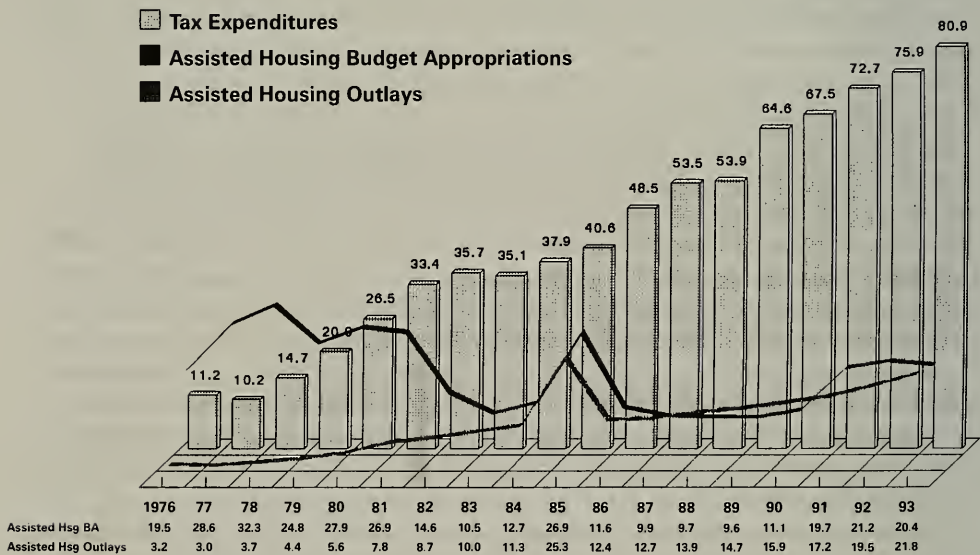
Faced with the tenacity of the problem, in 1987 Congress changed its approach and passed the Stewart B. McKinney Assistance Act, appropriating \$490 million to be spent on providing services and temporary shelter.

Although the passage of the McKinney Act signaled congressional recognition that homelessness is a persistent problem, the law stressed temporary relief measures and failed to provide for an integrated administration of its multiple disparate though related programs.¹⁷

Meanwhile, throughout the 1980s and into the 1990s the federal government failed to intervene successfully in the housing market in ways that effectively bridged the gap between housing costs and income. Federal outlays for construction of new affordable units dropped dramatically, as emphasis was placed on subsidizing market rents for low-income households through the Section 8 voucher program.

Figure 3

Federal Spending for Housing, 1976–1993
in Billions of Current Dollars



Source: National Low Income Housing Coalition and National Coalition for the Homeless. Reprinted with permission.
Note: 1986 reflects public housing refinancing, adding no units.

The federal government currently attempts to intervene in the housing market in three primary ways: *assisting the mortgage-lending industry* by insuring and subsidizing loans to homeowners and private developers; *rental subsidies*, which generate profits to landlords while helping only a small number of needy families; and *tax deductions* used as incentives for housing production and ownership, which help wealthy homeowners, developers, and investors.

Figure 3 compares the level of housing deductions (tax expenditures), which primarily benefit upper-income people, to the level of federal housing assistance programs, which primarily benefit lower-income people, for the period 1976–1993. By 1991, tax expenditures outnumbered assistance programs by more than two to one.

These interventions have predictably failed to substantially bridge the gaps between the incomes of poor people and the cost of housing. Instead, federal housing policies have intervened in the housing market primarily by reducing risks, guaranteeing profits, and granting tax breaks to the private sector while providing limited and uneven benefits to low-income housing consumers.¹⁸

Federal housing policies are fundamentally regressive, with the majority of tax breaks and subsidies going to upper-income people, as shown in Table 1.

Table 1

**Federal Housing Subsidies, Distributed by Income,
1988**
(estimated)

(Households in thousands; subsidies in billions)

Annual Income	Households (1986)		Tax Expenditures for Housing		Federal Outlays for Housing	Total	
	Number	%	Amount	%		Amount	%
Under \$10,000	17,130	19.1%	\$0.1	0.1%	\$10.1	\$10.1	15.7%
\$10,000–\$20,000	19,157	21.4%	\$1.1	2.2%	\$2.7	\$3.8	5.9%
\$20,000–\$30,000	16,350	18.3%	\$3.8	7.6%	\$1.0	\$4.9	7.6%
\$30,000–\$40,000	13,167	14.7%	\$5.4	10.7%	\$0.0	\$5.4	8.4%
\$40,000–\$50,000	8,667	9.7%	\$6.6	13.0%	\$0.0	\$6.6	10.2%
\$50,000 and over	15,007	16.8%	\$33.6	66.4%	\$0.0	\$33.6	52.2%
Total	89,478	100%	\$50.6	100%	\$13.8	\$64.4	100%

Source: Low Income Housing Information Service, *Special Memorandum*, Washington, D.C., April 1988. Reprinted with permission of the National Low Income Housing Coalition and the National Coalition for the Homeless.

Today the crisis in housing persists. Funding for affordable housing has plummeted and remains low despite the passage of the National Affordable Housing Act of 1990. Barry Zigas of the National Low Income Housing Coalition comments.

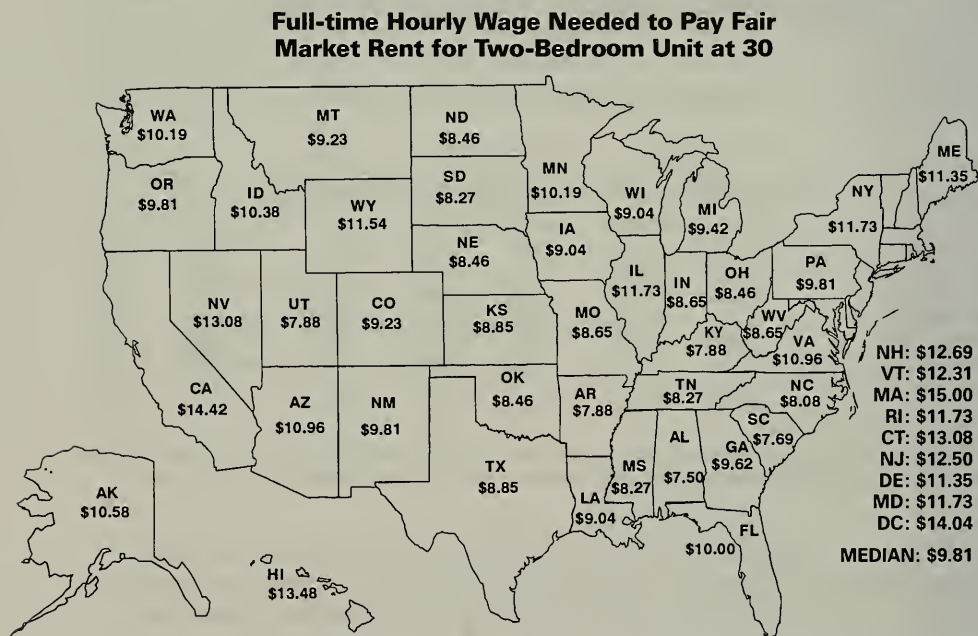
Total budget authority to finance housing assistance to very low income households has not increased since the Bush Administration took office. These current levels reflect the savage budget cuts pushed by the Reagan Administration. During 1977–81 HUD offered an average of 316,000 low income households assistance each year. During the following decade, HUD offered it to an average of only 82,000 households each year, a cut of more than 75 percent. The Bush Administration FY92 budget request would only assist about 90,000 households, no improvement over the last 10 years.

Even when fully funded at its authorized levels, the National Affordable Housing Act of 1990 would offer at most 250,000 households new housing assistance. This is a drop in the proverbial bucket when compared to the more than 9 million very low income renters that the Congressional Budget Office reports are eligible for HUD assistance but cannot receive it because of inadequate funding. The promising new programs in the Act will remain little more than promise unless Congress and the Administration come to terms with the need to boost spending.

In 1989, almost half of American households living below the poverty line paid more than 70 percent of their income for rent.¹⁹ Yet federal housing subsidies to those making more than \$40,000 far exceed subsidies to those making less than \$10,000 by 398 percent.²⁰

Despite the stark reality that these statistics impose, congressional leaders continue to search for new ways of explaining a simple economic problem. We know or should know that it is the growing disparity between the cost of housing and lack of adequate income that forces people into homelessness. Figure 4 indicates the hourly wage necessary to pay rent on a two-bedroom unit at 30 percent of income.

Figure 4

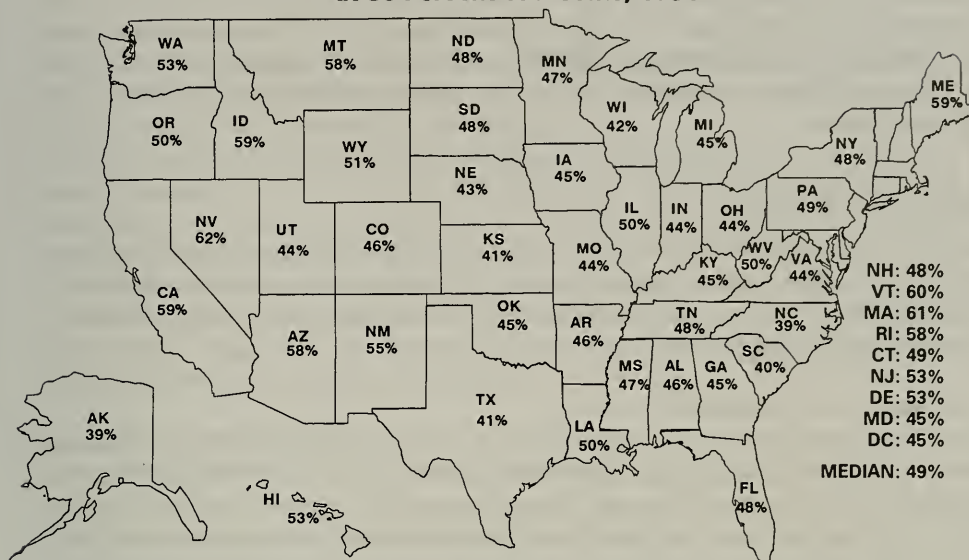


Source: National Low Income Housing Coalition and National Coalition for the Homeless. Reprinted with permission.

For example, 61 percent of Massachusetts households are unable to afford a two-bedroom apartment at 30 percent of income. (See Figure 5.)

Figure 5

Estimated Percentage of Renter Households Unable to Afford Fair Market Rents for Two-Bedroom Units at 30 Percent of Income, 1991



Source: National Low Income Housing Coalition and National Coalition for the Homeless. Reprinted with permission.

Nevertheless, by supporting programs that have little to do with bridging the gap between income and the cost of housing, the federal government continues to act as if it still does not truly understand the root causes of the problem. Both state and federal government continue to favor model programs focusing on the individual deficits of homeless people.

Government promotes policies that separate the poor into classes of deserving and nondeserving, labeling individuals on the basis of any number of attributes and attitudes. Homeless people, by virtue of their need to do all they have to do in public, are perfect subjects for dissection. Jonathan Kozol, author of *Rachel and Her Children*, a book about homeless families, said in an interview:

Suppose an expert went to a very poor country such as Haiti and came back to the United States and said: "I have a theory as to why there are all these homeless people in Haiti. The reason is poor values among the poor, a breakdown in family values, a curious preference for the streets." If anybody came back and said that he would be ridiculed instantly because it would be self-evident that he was trying . . . to avoid the obvious. But in the United States, people who do precisely the same thing are invited to the White House! They are considered valued experts . . . Their value is precisely in the fact that they spare us the painful recognition that in the United States, as in most of the world, there is such a thing as injustice.²¹

Because homelessness is such a relatively new phenomenon, and because, by definition, the lives of homeless people are more accessible to be scrutinized, they are the new "hot" subjects of these types of studies and programs. The reality of bad economic policies gets lost in some academics' pursuit to develop neat models that explain away harsh economic conditions and redefine them as problems of personal inadequacy.

In general, government has focused on the symptoms rather than the causes, attempting to shift the burden of homelessness away from basic housing and economic reform and toward a system of new poorhouses and treatment models. And, perversely, even though these “solutions” have not proven themselves to be effective in stemming the tide of poor people into homelessness, our leaders have taken them as centerpieces to their responses. This has certainly detracted attention from more fundamental issues — redefining the problem through practicing only a symptomatic response.

Main Survey Findings

In general, Massachusetts funders are eager to engage in dialogue about effective funding strategies for confronting the devastation of homelessness in the state. An analysis of these survey results and follow-up discussions with funders help identify funding trends in the state.

Prevention versus Emergency Services

In what we consider to be the most important finding, a full 87 percent of private funders expressed a desire to fund programs related to the prevention of homelessness; however, and conversely, only 20 percent consider themselves to be doing so. Instead, 80 percent spent the majority of their grant dollars on emergency services. These findings were made more interesting in that we did not originally define prevention for those surveyed. As a result “prevention” was open to broad interpretation and could have flowed from any of the above noted assumptive precepts.

Very simply, the large majority of private foundations wish to fund prevention yet nearly the same proportion do not do so, even when they are free to define it in their own terms. While we did not ask funders to identify prevention specifically, we did ask what other social welfare problems they saw connected to the issue of homelessness. Responses appear to be almost evenly divided between the more systemic (housing and economic factor) oriented and the attributive (individual pathology) oriented with little overlap between the two.

Homelessness and Its Connection to Other Social Welfare Programs

Of those surveyed, 60 percent claim that they saw programs concerned with substance abuse, programs serving the mentally ill, emergency services, and counseling services as related to the problem of homelessness. Fifty percent of respondents stated that they saw programs concerned with affordable housing, housing rehabilitation, advocacy, job training, and economic development as connected to homelessness. Surprisingly, only a 10 percent overlap existed between the two, suggesting a certain bipolarity rather than a more comprehensive approach among respondents.

Willingness to Fund Programs That Receive Government Support

The majority of funders (81%) indicated a willingness to fund programs that receive governmental support. Follow-up discussions with funders, however, suggested that they feel dissatisfied with the way government approaches prevention of the problem of homelessness and its associated policy issues. Many funders wish that “government

would do more” and be “more creative and more responsive.” Many question whether funding in the area of homelessness should be the responsibility of private-sector funders in the first place.

Policy Statement

Only 2 percent of respondents stated that they have a policy statement which addresses funding of programs dealing with the issue of homelessness; 96 percent stated that they did not have such a statement.

Overall, many of the comments from this section indicate that the majority of funders are not interested in creating a formal policy. Many feel that it is not their responsibility to create one or that they are not interested in creating specific policy around an issue like homelessness.

Although several funders commented that they were in the process of establishing policy, none claimed that they already had a working policy in place. These comments seem to suggest that formulation of policy around funding of homelessness is a relatively new and infrequent phenomenon.

Collaboration with Other Funders

The survey asked whether funders collaborated with colleagues on homeless projects. Of those who responded, 50 percent do not. Twenty-five percent indicated that they have, and 25 percent did not respond to the question.

Outlining Trends in Funding of Specific Program Areas

Foundations were asked whether they fund programs addressing any of the following areas: homeless shelters; transitional housing programs; affordable housing initiatives; battered women’s services; community services for the mentally ill; public policy research and advocacy around homelessness; advocacy around income issues; homelessness and AIDS; homelessness and health care; homeless youth programs. Respondents who indicated that they did in fact support any of the above program areas, were asked whether they had increased, decreased, or maintained funding at the same level for these same program areas over the past two years.

Homeless Shelters

Fifty-nine percent of respondents support homeless shelters. Of these, 32 percent increased spending, 11 percent decreased spending, 26 percent maintained spending on the same level, and 31 percent did not respond to the question. Overall, the amount of money going toward homeless shelters increased.

Transitional Housing

Of those funders who responded to the survey, 62 percent make grants toward transitional housing. On average, grants in this area have increased in the past two years; 35 percent increased spending, 10 percent decreased spending, and 30 percent maintained spending at the same level. Twenty-five percent did not respond to the question. Again, the overall amount of money going toward transitional housing increased.

Affordable Housing Initiatives

Fifty-six percent of the respondents support affordable housing initiatives. Thirty-four percent increased spending, 5 percent decreased spending, 34 percent main-

tained spending at the same level, and 27 percent did not respond to the question. On average, it appears that funding in this area has been fairly level.

Battered Women's Services

Sixty-eight percent support programs that serve battered women. Thirty-six percent maintained spending for this purpose at the same level, while 23 percent increased and 9 percent decreased spending.

Community Services for the Mentally Ill

Of the funders surveyed, 46 percent support programs that provide community services for the mentally ill. Their support remained the same, with 60 percent having maintained funding at the same level, 20 percent increasing funding, and none decreasing it.

Public Policy Research and Advocacy

Twenty-eight percent support public policy research and advocacy. On average, funding for these efforts has remained the same: 22 percent increased spending in this area, 67 percent maintained it at the same level, and 11 percent decreased funding.

Advocacy Relative to Income Issues

Twenty-two percent fund advocacy relative to income issues. Funding in this area declined. Fifty-seven percent of those who support advocacy decreased such spending, 14 percent increased spending, and 9 percent stated that they maintained funding at the same level. This appears to be a program area for which support is minimal and decreasing overall. Since it is a central issue in homelessness, such a decrease should be of some concern.

Homelessness and AIDS

Thirty-four percent support programs for homeless people with AIDS; 46 percent increased spending, 36 percent maintained levels of spending, and none decreased spending. Overall, funding in this area increased.

Homelessness and Health Care

Twenty-five percent support health care services for homeless people. Funding in this area remained the same. Fifty percent maintained similar levels of spending. Twenty-five percent increased spending, none decreased spending, and 25 percent did not respond to the question.

Homeless Youth Programs

Of the respondents, 37 percent support homeless youth programs. Funding in this area remained basically the same — 67 percent maintained spending levels, 8 percent increased and none decreased funding. Of interest is the fact that there are very few programs that support homeless youth, but those few are the most frequently cited programs that foundations support overall.

Establishing Priority Level of Grant Making Relative to Homelessness

Most of the foundations that traditionally make grants around poverty-related issues rank the problem of homelessness as a middle priority in their funding strategy. The survey asked respondents to rank, on a scale of 1 to 5 with 1 high and 5 low, how high a priority the issue of homelessness is in their funding strategy. The average response was 3, indicating that the majority of respondents consider homelessness a priority in their funding strategy, but not their highest priority. Discussions with funders suggest that those issues which funders generally view as a higher priority than homelessness are substantive areas which coincide most consistently with the overall mission of the foundation. In other words, it's not that homelessness is not a priority in and of itself but as it is connected to other poverty-related issues that are more closely associated with the primary mission of the foundation.

As the problem of homelessness escalates and the demographics of the homeless population shift, foundations whose funding priorities fall in areas other than homelessness are making additional necessary grants in the homelessness area. For example, as the population of homeless youth expands in the state, a foundation whose fundamental mission is to fund youth-related programs is now funding programs that serve homeless youth. The foundation may become increasingly interested in issues of homelessness and view homelessness as directly connected to its primary mission. As the demographics of the homeless population in Massachusetts have changed, the funding priorities and strategies of individual charitable organizations have shifted accordingly.

Trends in Spending Levels

While foundations do not fund homelessness as their highest priority, they nevertheless consistently maintained or increased funding toward homelessness in 1989–1990. In response to the survey question, "In the past two years have you increased or decreased funding for programs serving the homeless?" the majority of respondents stated they had either increased or maintained funding at the same level. Thirty-seven percent stated that they had increased funding in the area, 31 percent maintained funding at the same level, and 6 percent decreased funding. The survey responses showed no significant correlation between the previously stated priority level of funding relative to homelessness and spending patterns.

An initial hypothesis was that funders who viewed homelessness as a high priority in their funding strategy also increased funding. Overall, it seems that on the individual organizational level there is little connection between priority level and funding patterns. However, in the aggregate, spending around homelessness increased in the two-year period even though homelessness is not the highest priority of foundations' funding strategies.

Funding Emergency Services for Homeless People

Foundations were asked how much of their funding goes toward emergency services for homeless people, for example, shelter. Results showed that of all the money foundations spent on homelessness, 80 percent of spending went toward emergency services, while only 20 percent was for prevention.

Thinking Through Future Directions: Developing a Funding Strategy

Recent general trends among givers in the Boston area show a willingness to examine more carefully the most effective role that private funders can play in situations where public policy needs to be changed. In fact, according to the *Chronicle of Philanthropy*, giving to nonprofits concerned with public policy and other social causes increased nationally by 28 percent in 1990.²²

The Fund for the Homeless believes that public policy work is a vital component of any philanthropic response to homelessness and that attributing the problem of homelessness to the pathologies of individuals distracts from the overwhelming transformative work prescribed by a systemic analysis. It also does not mitigate the ever increasing influx of poor people into homelessness.

Emergency shelter and related services, though essential to saving lives put at risk, are also unable to stem the problem at its source points.

Even our involvement in low-income housing development is necessarily limited in scale. At a recent meeting of the Council on Foundations, Barry Zigas, director of the National Low Income Housing Coalition, explained that no matter how generous private funders wanted to be in the area of housing development, they could never come up with the \$180 billion needed to provide affordable housing to 9 million eligible households.

I don't think it's appropriate for foundations to emphasize their investments in low income housing development the way they have. I don't think it's effective leverage. I don't think it's a realization about the magnitude of this problem and I don't think it's the right allocation of the various responsibilities within a civil society whose responsibility it really is to make sure that everybody in this country has access to decent, affordable housing. I think your impulses are right, I'm glad somebody is doing it, but I'm afraid you're getting sucked into a vacuum the Federal government has left and I think it's a mistake.²³

A parable often quoted by Kip Tiernan, a local political and moral activist, has us at the banks of a river where babies are being swept downcurrent. As townspeople, we are morally required to save those babies, but if the babies continue to float down to us, presumably we would also see it as our responsibility to go upstream to find out how we might help to prevent their relinquishment to the river in the first place. One response without the other is probably not completely legitimate.

We, as private funders, must search our hearts and our minds for the right direction in funding homelessness projects. We should also keep in mind a more positive vision of healthy, safe, and productive communities.

It is our belief that the realization of this vision will require not only strong policy action on both the housing and income fronts but also the involvement of homeless, formerly homeless, and low-income people in designing and advocating for livable communities. In other words, the situation requires effective citizen action.

Suggestions on Funding Projects Related to Homelessness

In general, the choice of where you direct private funding for social programs should reveal (1) your analysis of the problem, (2) what you believe to be effective ways to

address the problem, and (3) what the mission and traditions of your particular giving program are.

Few of us can consider ourselves to be "experts" in all the areas in which we are required to make grants. However, it is important to scrutinize the assumptions on which we base our analyses of problems. Because homelessness has burgeoned only in the past decade, the examination of policy, market, and economic changes related to it is somewhat more realistic a task than with other, more long-standing and multifaceted problems such as crime. The development of a systemic and solution-oriented response would seem to be more possible.

Whether or not we see the problem as being tractable in the systemic sense and how we go about crafting our approach to it depends on our assumptions and resulting analyses.

Because the public sector has shown enormous reticence in its recognition and definition of the problem, the private sector is left with an increased responsibility to take the lead in developing and pursuing solution-oriented strategies. Unfortunately, this will have to be accomplished during a period of enormous immediate need among those who are currently homeless. Particularly during the period of profound budget cuts in Massachusetts, decisions about where to place already stretched grant dollars will be extraordinarily difficult.

Our choices, then, should be preceded by the questioning of our own assumptions and the pursuit of an increasingly deeper understanding of the issue. What follows is a series of questions that funders can ask themselves prior to funding homelessness programs.

Questions for Funders

1. What analysis related to the root causes of homelessness do I accept?
Do I believe that homelessness has always been with us and is basically an intractable subsegment of poverty?
Do I believe that homelessness is primarily due to a lack of access to affordable housing combined with low incomes?
Do I believe that homelessness is primarily due to individual infirmities, pathologies, or weakness of character?
Do I need more information in order to develop a clear analysis?
2. In what ways do we intend to
relieve immediate suffering?
develop limited-size but replicable models for either community development or social service delivery or both?
address root causes either through an attempt to transform policies or public opinion?
3. How is my board or contributions committee likely to respond to this direction? Do they have a shared analysis of the problem? If they are likely to respond negatively, what might I be able to do to pave the way? (That is, develop a policy paper, bring in a speaker, send or recommend readings to them, enter into collaboration with other funders?)
4. What is the involvement of homeless people in the projects that are requesting funding? Is there an avenue for real constituent participation in program and

policy development? Is there a method for leadership development among homeless and poor people in the project?

If You Choose to Fund Shelter and Emergency Service Projects

1. Go on a site visit and ask yourself, Are people's human rights and dignity respected in the practices and surroundings of this project? Would you wish to be treated this way if you were homeless?
2. Ask the guests *and* the service provider:
How are homeless people involved in setting policies for, developing the programs of, and sustaining the organization (other than providing the billable client base)?
Is there an accessible and well-used range of services/resources available to guests, including
housing search mechanisms?
aid in identifying available financial resources?
mental health and substance-abuse treatment referrals?
domestic abuse referrals?
3. Is there a place to store personal belongings? Is there a place for people to make calls for employment/income and/or housing-related opportunities? Can beds be reserved from one night to the next? What are the "in by" and "out by" hours? Consider the impact of these and other policies on personal safety, comfort, and dignity. Considering that shelter is supported by government in this state, is the worth added by your grant significant?

If You Choose to Fund Projects Aimed at Systemic Change

1. What policies, practices, and interests contributed to the creation of the problem of homelessness?
2. What issues need more research? (Call the Homelessness Information Exchange at the Fund for the Homeless, 617-723-7415.)
3. What issues must be approached on the local, state, and national levels?
Is the grantee capable of building support on the right side of the issue being taken up? Is a clear unfractionalized analysis of homelessness being put forth?
4. Are those who are directly affected involved in developing the goals, strategies, and tactics?
5. Are all possible allies identified? Are there plans for their eventual participation?
6. What are the milestones? How will the project be evaluated? 

Appendix A
Study Methodology

The process of collecting and disseminating information on the funding practices and patterns of Massachusetts funders in the area of homelessness has been twofold: (1) Sixty-seven Massachusetts funders were selected on the basis of attained knowledge of their past giving records and expressed interest in making grants in poverty-related areas, including homelessness. The response rate of the local funder groups was about 65 percent (forty-five funders answered the initial group of survey questions). (2) Follow-up phone conversations with some funders were conducted and a focus group and forum event with Associated Grantmakers of Massachusetts was organized to address follow-up issues and questions and to generate more qualitative data.

The following foundations were surveyed:

American Express Foundation
The Baldwin Foundation
Bank of Boston Charitable Foundation
Bank of New England Foundation
Better Homes Foundation
Boston Fatherless and Widows Society
Boston Globe Foundation
Boston Safe Deposit and Trust Company
Boston Women's Fund
John W. Boynton Fund
Harold Brooks Foundation
Cabot Corporation Foundation
Cambridge Community Foundation
Carlisle Services, Inc.
Charlesbank Homes
The Alfred E. Chase Charity Foundation
Clipper Ship Foundation
Cowan Corporation Foundation
Digital Equipment Corporation
Discount Foundation
John Donnelly Trust
The Charles Stark Draper Laboratory, Inc.
Eastern Charitable Foundation
Families U.S.A. Foundation
Fidelity Investments
Freeport, Inc.
Greater Lawrence Community Foundation
Greater Worcester Community Foundation
Campbell and Adah F. Hall Charity Fund
Charles Hayden Foundation
Haymarket People's Fund
Hill, Holliday, Connors, Cosmopolos
The Hoche-Scofield Foundation
Hyams Foundation
Island Foundation
Ittleson Foundation, Inc.
John Hancock Mutual Life Insurance Co.

The Knistrom Foundation
Lend A Hand Society
Arthur D. Little Foundation
Loomis, Sayles & Company, Inc.
Lotus Development Corporation
Margo Foundation
Massachusetts Bar Foundation
Massachusetts Legal Assistance Corporation
Joyce Mertz-Gilmore Foundation
Metropolitan Life Foundation
The Millapore Foundation
The New England
New England Telephone
Norton Company Foundation
Old South Fund
Theodore Edson Parker Foundation
Amelia Peabody Foundation
Joseph Perini Memorial Foundation
Polaroid Foundation
Rebecca Pomroy Foundation
Pringle Charitable Foundation
Sidney H. Rabinowitz Family Foundation
A. C. Ratschesky Foundation
Reebok Foundation
The Riley Foundation
Sanders Fund, Inc.
The Starr Foundation
Abbot and Dorothy Stevens Foundation
Stop and Shop Companies, Inc.
Stratford Foundation

Appendix B

Who Is Homeless in Massachusetts?

There is disagreement among policymakers and researchers about how to define the root causes of homelessness and who is, in fact, homeless. This confusion makes the task of assessing both the numbers and needs of a changing homeless population challenging. Although various research groups and local governments have attempted to assess numbers and needs, few of these efforts follow a methodology that accounts for the total scope of the homeless population. As a result, it is hard to come up with an accurate number of homeless people on a national and local basis. In addition, because homelessness interacts with so many other poverty-related areas, isolating its existence can be problematic. Nevertheless, compiling information from several different sources can generate potentially useful information, especially about significant trends in the area.

According to the 1990 Comprehensive Homeless Assistance Plan for Massachusetts, estimates of the homeless population in the commonwealth set the current number at 10,000 individuals. The Massachusetts Coalition for the Homeless sets the number at 25,000. It is estimated that nearly 75 percent of this population are families. This estimate does not include thousands of people who are living in overcrowded or doubled-up housing situations.

Families

Trends show that in recent years families comprise the fastest growing segment of the homeless population. In 1983, only 25 percent of the Massachusetts homeless population consisted of family units. This number has increased significantly and projections for fiscal year 1991 suggest that the welfare department expects to serve close to 5,000 homeless families in need of emergency shelter and provide another 37,000 with homelessness prevention benefits.²⁴

Of this population, 80 to 90 percent of all homeless families are headed by a single, female parent between eighteen and thirty-five years old and an estimated 80 percent of homeless families rely on AFDC as their principal source of support. Children have entered the homeless population in significant numbers. Two-thirds of homeless children are under the age of six and nearly one-half are under four years of age.

Individuals

According to the Massachusetts Coalition for the Homeless, there are between 5,000 and 7,000 homeless single adults in Massachusetts. According to the Comprehensive Homeless Assistance Plan (CHAP), overall assessment of need shows that of individuals in twenty-seven shelters across the state, 22 to 35 percent experience severe mental illness, 20 to 30 percent have a dual diagnosis of mental illness and substance abuse, 50 to 70 percent have major substance-abuse problems, 10 percent have chronic physical illness, and 20 percent have experienced a primary economic loss leading to homelessness. Clearly, there is overlap among these categories.

Veterans

According to the Massachusetts Office of the Commissioner of Veterans Services, it is estimated that veterans comprise 30 percent of homeless individuals in the city of Boston's shelters. A survey conducted in 1989 showed that there may be 2,500 homeless veterans on the streets or in shelters. Of this population, 75 to 85 percent are Vietnam era vets and fewer than 5 percent are female; over 50 percent have psychiatric disorders; almost 60 percent have substance-abuse history (45% alcohol, 12% other drugs); and over 40 percent have other serious medical problems.

Elderly

A growing number of Massachusetts elderly people are homeless. According to the CHAP, in 1988 there were 1,200 homeless elders in Massachusetts, most of whom

were in Boston. The majority of this group, 70 percent, are men, although the number of women in shelter is increasing. The burdens the elderly face when trying to locate housing are especially significant.

Many private landlords are reluctant to rent to the elderly because of poor past housing history, and placing elders in nursing homes poses another set of problematic issues. Because people live longer today, the base numbers of elderly people in the United States is growing. As the problem of homelessness also grows, we can expect to see more elderly people in shelters and in desperate need of affordable, decent housing.

Individuals with AIDS

According to the CHAP, the Massachusetts Department of Public Health estimated that 1,405 persons with AIDS live in Massachusetts. This report also estimates that 30 percent of homeless people living in Boston are infected with HIV. (This number does not include children or women in family shelters.) Over 30 percent of people with AIDS are in acute care hospitals because no community-based or residential alternatives are available to them.

While there is a lot we do not know about the relationship between homelessness and AIDS, we do know that both problems are escalating and that the numbers of homeless people with AIDS will continue to grow in the next decade. The AIDS ACTION Committee of Massachusetts has reported that over 25 percent of its caseload, approximately 250 clients, include people who are homeless or in imminent danger of homelessness.

Pregnant and Parenting Teen Households

Young single-parent families comprise the fastest growing segment of the homeless population. A joint report conducted by the Citizens Housing and Planning Association and the Alliance for Young Families in 1988 concluded that 2,151 homeless pregnant or parenting teens were in the following facilities:

Family shelters	813
Adolescent shelters	100
Hotels/motels	380
Living on the streets	63
Temporarily living with friends or relatives	795
Total	2,151

The majority of these families are white, headed by young women aged eighteen and nineteen, with one child, and dependent on AFDC.

Mentally Ill

According to the Department of Mental Health (DMH), approximately 2,150 Massachusetts homeless people are mentally ill. Shelter providers argue that the number is probably higher, and they should know, since shelters have often become the facilities of last resort for mentally ill persons. The lack of affordable housing has an impact on all handicapped people in a particularly devastating way. Mentally ill people are often discriminated against by housing authorities and other housing providers. This, coupled with DMH's failure to provide comprehensive services, has left many of them with few options. It seems as if the commonwealth is capable only of providing mentally ill people with either a shelter bed or a state hospital bed at high financial cost to the state and at a terrible human cost to persons with such problems. As the DMH budget is further dismantled, mentally ill homeless persons are likely to have fewer resources available and to experience more devastating illnesses.

Appendix C

General History of the Fund for the Homeless

Acting in partnership with other local funders, the Fund for the Homeless channels private resources toward the elimination of homelessness in Massachusetts. Since 1983, the Boston Foundation has supported and housed the Fund as an integral part of its commitment to eradication of this problem. Over these years, the Fund's mission has evolved in response to the growing and changing needs of the homeless population.

For the past eight years, the Fund for the Homeless has worked to decrease the gap between the needs of homeless people in Massachusetts and the sheltering resources available to them. In its first stage, the Fund launched a capital grant-making program, distributing \$1.3 million to shelters between 1983 and 1987. In 1987, responding to the management needs of a host of newly established shelters, the Fund created the Shelter Technical Assistance Project, which has provided guidance, consultation, and workshops to over ninety Massachusetts shelters.

Today, however, the gap between need and services in the homelessness arena is wider than ever. As the number of Massachusetts shelters has skyrocketed from three to more than 130 over the past seven years, there has been a growing realization among advocates in the housing and homelessness fields that the continued development of emergency facilities and the current level of low-income housing production will not serve to stem the tide of poor people joining the ranks of the homeless.

In response, the Fund for the Homeless has created Beyond Shelter, a project that aims to address the root causes of homelessness and thus to prevent many poor families and individuals from resorting to a life in the state's overcrowded shelters, in hotels or motels, or in the streets.

Beyond Shelter has three main operational areas: it acts as a regional center for a national information exchange that provides data on homelessness; it convenes disparate groups concerned with homelessness to bring about a common agenda for its prevention and eradication; and it provides modest financial support and technical assistance to projects that educate the public and provide for citizen action to end homelessness.

Notes

1. See Appendix A for methodology.
2. Housing-dependent service models refers to housing programs which stipulate that the client must agree to receive services while being housed.
3. David J. Rothman, *The Discovery of the Asylum* (Boston: Little, Brown, 1990), 6.
4. Peter Marcuse, "Neutralizing Homelessness," in *Socialist Review*, Center for Research and Education (Washington: Winter 1988).
5. Peter M. Senge, "The Leader's New Work: Building Learning Organizations," *Sloan Management Review*, Fall 1990, 17.
6. Comprehensive Homeless Assistance Plan of Massachusetts (CHAP), Commonwealth of Massachusetts Executive Office of Human Services, 1990.
7. U.S. Congress, House Ways and Means Committee, "Green Book," 1991.
8. Massachusetts Bureau of Labor Statistics.
9. Nominal grant information from the Massachusetts Department of Public Welfare.
10. Testimony of Robert Greenstein, director, Center on Budget and Policy Priorities, before the House Committee on Ways and Means, March 13, 1991.
11. Massachusetts Bureau of Labor Statistics.
12. Massachusetts Department of Public Welfare Budget Office.
13. Sar Levitan and Susan Schillmoeller, *The Paradox of Homelessness in America* (Washington: Center for Social Policy Studies of George Washington University, 1991), 23.
14. Ibid.
15. Ibid.
16. Marcuse, "Neutralizing Homelessness," 77.
17. Levitan and Schillmoeller, 25.
18. Institute for Policy Studies Working Group on Housing with Dick Cluster, *The Right to Housing: A Blueprint for Housing the Nation* (Washington, D.C.: Institute for Policy Studies, 1989), 15.
19. Ibid.
20. Ibid.
21. Hunger Project, *Hunger Action Forum*, February 1991.
22. Stephen Greene, "1990 Giving: Smallest Increase in Three Years," *Chronicle of Philanthropy*, June 4, 1991, 1.
23. Barry Zigas, Council on Foundation Annual Meeting, Workshop, "The Homeless: Will They Always Be With Us?" Chicago, April 1991.
24. CHAP, 3.

Homelessness

The Politics of Accommodation

Kip Tiernan

This article considers the problem of poverty, with homelessness as the centerpiece. A survey of the problem and its roots and ancillary branches includes (1) a description of poverty in Boston (and America) from 1974 to 1991, its effects, its victims, and its predictable effects on the economy; (2) a description of displacement and of the homelessness that results from it; (3) a description of the immediate response to displacement and homelessness, that is, shelters; (4) a description of the institutionalization/professionalization/ossification of the response (more shelters); and (5) an outline of the terms of the new debate and suggestions for what a renewed, redirected effort to eliminate poverty and homelessness should take.

Situations of cultural acceptance breed accommodating complacency.

— Walter Brueggmann, *The Prophetic Imagination*

Homelessness in this nation increases annually by 25 percent.¹ It is not an emergency but rather a chronic condition to which Americans have accommodated themselves for many years. The growing polarization in American society has created painful inequities and has had a profound effect on our ability to distinguish good public policy from bad politics. We have allowed our realities to be redefined by those who would deny the real realities, by our national leaders who set the terms of the debate around standards of living. Shelters have become, in a few short years, acceptable standards of living for thousands of American citizens whose economic status isolates them into what may well be a permanent state of exile.

For the past twenty or more years as an urban minister, I have been an advocate for fragile populations, ever since I realized that to learn the truth, one must listen to those whose realities are created for them by those in power, a lesson I learned when I moved to Roxbury in 1970 and became a member of the team ministry at Saint Philip/Warwick House. No one chooses poverty; it is selected for them by

Kip Tiernan, the founder of Rosie's Place, the nation's first drop-in center and emergency shelter for women, is codirector, with Fran Froehlich, of the Poor People's United Fund and the Ethical Policy Institute of the University of Massachusetts at Boston.

somebody. In an effort to alleviate some of the suffering of these populations, I have choreographed, developed, or helped to develop a number of alternative structures when the ones we had no longer seemed to work. The first, and the one to which I have the greatest attachment, is Rosie's Place, which I began over seventeen years ago when I saw women "passing" as men to get a meal at the Pine Street Inn or at Haley House, a Catholic Worker for men in Boston's South End. The South End was one of the first neighborhoods in the Boston area to be "redlined" by banks in the early 1970s, and later one of the first areas to be "gentrified" by real estate developers for the young "urban pioneers" moving back to the city their parents deserted during the "great white flight" of the 1960s.

I was told at the time that there were no homeless women in Boston. This was one of my first run-ins with the denial of reality. At that time there were no categorical or gender statistics on homeless people. Homeless women then tended to be more anonymous, more secretive, more humiliated by the experience of homelessness. For the next decade, I started or helped start several other so-called emergency alternatives, all of which are now pretty much institutionalized, including, in 1978, the Boston Food Bank. Because funds were rapidly drying up for local community groups, some of which were previously funded by the federal government, between 1980 and 1983 I helped to start three new funding sources, including the Poor People's United Fund, the Boston Women's Fund, and Communityworks. One philosophy all of these groups have in common is the belief in grassroots organizing and the power of a single person to act positively in the human interest.

I was a founding member of the Massachusetts Coalition for the Homeless in 1982, and in 1983 headed a panel on the Governor's Advisory Committee on Homelessness. We had twenty-two subcommittees, but nothing on medical services for homeless people, so the group I chaired was on the medically homeless. Our recommendations became the basis for the first funding for Health Care for the Homeless. During those years, I continued to help other groups get off the ground, including the Up to Poverty campaign for welfare mothers. I began to realize that all my efforts were indeed helping hands, but I was not solving anything, I was not preventing homelessness, I was not stopping poverty, and if I were to look at it honestly, I would have to say I was helping to perpetuate problems.

The Seductive Rise of Shelters in Massachusetts

In 1982, Massachusetts had two state-funded shelters. Homelessness was on the rise, and when he returned to office, I suggested to Governor Michael Dukakis that homelessness would not be solved by the creation of a shelter system, that he might look at the growing lack of affordable housing — people were being displaced because they could no longer afford to live in their old neighborhoods — that the cost of rentals was out of proportion to people's incomes. Yet by 1989 we had over 130 state-funded shelters in the commonwealth and needed many, many more. It became depressingly clear, at least to me, that an entire class of people was being condemned to shelters and that the emergence of a new public sector — the professional pedagogy of shelter "experts" — would be managing these people and maintaining them in shelters from coast to coast. Redlining, welfare cutbacks, deinstitutionalization, the higher cost of living — all had come together in the 1970s

to create an economic problem that was not going to be solved by the creation of a “shelter industry,” yet that is what we have.

In his first administration, 1974 to 1978, Governor Dukakis, in a fit of fiscal austerity and against the recommendations of an econometric study, removed thousands of people from the welfare rolls. The termination of General Relief cash and medical assistance had numerous disastrous effects on many citizens of the commonwealth, among which was the increase in the number of homeless people. In an attempt to evaluate the impact of the policy changes, the Office of Research and Planning of the state’s Department of Public Welfare conducted surveys of employable and unemployable former recipients almost three and a half months after the cutbacks went into effect; the results were published in the Abramowitz report.² Its primary findings included the fact that the average respondent was forty-five years old with a ninth-grade education, and the reported need for medical and dental care and medicine during this period was very great. The most common health problems reported were bronchitis, pneumonia, and heart conditions; recipient discouragement was a major factor in the terminated medical and dental care. Access was so difficult that people just gave up. The denial of medical or dental care was a chilling indication of what can happen if you are sick and poor. The report confirmed the correlation between health and housing.

By 1978 I was a familiar figure at City Hall and the State House, where I frequently requested help for people without housing and medical services. I also was an advocate for welfare reform, condominium moratoriums, rent control, disposal of Boston Redevelopment Administration housing, specialized housing for the emotionally fragile, and adequate welfare assistance for mothers and children. All to no avail. At the time, I warned policymakers and politicians that they would soon have to be considering “family shelters” for the new poor, but was told not to worry — it was all in the pipeline. The pipeline had now become a rash of family shelter motels and welfare hotels.

Toward a Political Theology: Bridging the Values and Vision Gap

So what do we do? I have infinite hope that we can be caring rather than custodial, enabling rather than enforcing. But we must begin by assessing the values we have put in place in lieu of a decent standard of living for all Americans. We have in the past proven we can, by the manner in which we first looked at homelessness in Boston. Shelters, soup kitchens, and, in general, an outpouring of generosity by the public and private resources in the late 1970s proved to be responsive to the problem. We all made attempts to alleviate the suffering of those forced into the streets. But it is time now to begin eliminating the causes for the suffering, and that requires a dispassionate look at ourselves and a firm will to stop poverty from becoming an acceptable chronic condition that keeps us in our jobs. Whatever political, social, and spiritual values we may have must be turned into a political theology that responds economically to the needs of all homeless people — and people who are about to become homeless. We have gradually accepted a Third World in America, a world we are now “managing” by maintaining shelters, soup kitchens, and food pantries. But we must stop managing and begin changing.

I frequently use a story from the Inter-Religious Task Force for Social Ministries, written in 1979. From the book *Must We Choose Sides?*, it is called "A Parable of Good Works" and goes like this.

Once upon a time there was a small village on the edge of a river. The people there were good and the life of the village was good. One day a villager noticed a baby floating down the river. The villager quickly jumped into the river and swam out to save the baby from drowning.

The next day, this same villager was walking along the river bank and noticed two babies in the river. He called for help, and both babies were rescued from the swift waters. And the following day four babies were rescued from the swift waters. And the following day, eight, and then more and still more.

The villagers organized themselves quickly, setting up watch towers and training teams of swimmers who could resist the swift waters and rescue the babies. Rescue squads were soon working 24 hours a day. And each day the number of helpless babies floating down the river increased.

The villagers organized themselves efficiently. The rescue squads were now snatching many children each day. Groups were trained to give mouth-to-mouth resuscitation. Others prepared formula and provided clothing for the chilled babies. Many, particularly elderly women, were involved in making clothing and knitting blankets. Still others provided foster homes and placement.

While not all the babies, now very numerous, could be saved, the villagers felt they were doing well to save as many as they could each day. Indeed, the village priest blessed them in their good work. And life in the village continued on that basis.

One day, however, someone raised the question, "But where are all those babies coming from? Who is throwing them into the River? Why? Let's organize a team to go upstream and see who's doing it." The seeming logic of the elders continued. "And if we go upstream, who will operate the rescue operations? We need every concerned person here." "But don't you see," cried the one lone voice, "if we find out who is throwing them in, we can stop the problem and *no* babies will drown — by going upstream we can eliminate the cause of the problem."

"It's too risky."

And so the numbers of babies increased daily. Those saved, increased; but those who drowned increased even more.³

Americans have always rushed to the aid of the defenseless. In fact, philanthropy is built on the altruistic impulses of middle- and lower-class donors. More funds are generated for "good causes" in America than perhaps in any other industrialized country in the world. The historic traditionalists, such as Rockefeller, Ford, and Mellon, have donated millions to charity to help alleviate human suffering. There are no current statistics on the benevolence of Massachusetts foundations during the current homeless crunch, but millions have been cheerfully donated to shelters, transitional housing, special housing, soup kitchens, food pantries, and other "emergency" type agencies during the period 1975–1990. Yet nothing has changed.

Over the past twenty years I have helped pull a lot of babies out of the stream. I have also, on occasion, gone upstream to find out who is throwing them in. But I have run into the same problem the villager who asked the question did. So I continue to do both, but as one who has a lifetime commitment to poor and homeless

women, I find my frustration level growing as I see the rising tide of poverty becoming increasingly difficult to deal with on any reasonable level.

Last year I had the honor and privilege of being asked to speak at the first Homeless Women Speakout in Massachusetts. The day-long event included many workshops conducted by homeless and previously homeless women. I have constantly been amazed and inspired at the strength and courage of my homeless sisters, who continue to be the wind beneath my wings. Together we have walked some dark and lonely nights and years together, and it is those women who have held me in my own dark hours. Who else indeed knows more about homelessness than homeless women themselves — women who have had to face the indignity of being just another face in the crowd, who have suffered the slings and arrows of a mean and hostile world? Together, with them, we have discovered that there is no middle way, that one stands with the crucified or the crucifier. I learned from poor people that to learn the truth, one must listen to those whose realities are created for them by those in power. We have discovered that to be homeless is to be an outcast, rejected, alienated, exiled.

We consider the extreme irony together, for what is Christmas but the greatest American celebration for a homeless little boy? Homeless women and I have learned together that no prophet, no politician, no provider, can call us to a change of heart more powerfully than the poor, the exiled, the alienated. I, too, consider myself an outcast. It keeps me safe and, I hope, honest. We have learned in our struggle that we must struggle to stay in that struggle, and that it is all one struggle. And that we must have faith in each other and we must never let anyone buy us off. To have the courage to speak out, to have the will to go on, to have the guts to say “We have a right to our own place, our own lives, our own dignity, our own self-esteem” is an important step in our own liberation. And one does not always find that kind of courage in a shelter.

Homeless women are the real heroines and the real experts. They are the real witnesses to man’s inhumanity to woman. Homeless women are the survivors of a terrible war on the poor. We have accommodated ourselves to a world of alternatives instead of options. The only alternative to homelessness is a home, and the only alternative to hunger is food on your table. The world of shelters, which was created as a stopgap, has become an acceptable standard of living for thousands, but it is not acceptable to us. Shelters have become the burnt offerings of the twentieth century, and we must begin to question their future if we are to have any. Millions of dollars are spent on workshops, seminars, conventions, reports, on demographic studies and research. But we know we could have saved them a lot of money by stating, simply, that housing ends homelessness — along with a job and decent education and medical access. We want the same things all those nice folks who go to seminars want: a decent standard of living.

The pain of being homeless — the endless waiting in welfare offices, the thoughtless dismissal, the terror of the streets, the endlessness of the long, dreary days, especially Sundays. The burdensome struggle to carry everything you own with you, the desperation of loneliness, the fear when the sun goes down, the biting cold of a careless February afternoon. The longing to have just five minutes alone with your kid for just one night, the distant memory of shared moments of joy and peace a long, long time ago. These are all real things that happen to real people. Homeless women speak to us of the real priorities and the importance of the necessities of

life, including the little things like combs and birthdays, the things we all take for granted. America denied the reality of homelessness for a long time. In fact, we allowed the government to redefine our realities, and we continue to allow the governor of Massachusetts to define reality. It is a tragic mistake.

All of us in human services live in a world of nightmares these days, and visions are hard to come by. But I do know this: scattered somewhere in all of our agonizing agendas are some common bases we must look at, to reclaim the moral vision we once held so dear. Perhaps we must learn to start all over again. We come from different experiences, but we must begin to operate out of a common base. Somehow it is important that we all speak the truth together. We can gain the strength of one another only when we operate out of a common value base. Perhaps what we must envision is a prophetic as well as pragmatic imagination. Walter Brueggemann, in *The Prophetic Imagination*, tells us one must nurture, cherish, and evoke a consciousness around oppression to develop a prophetic imagination!⁴

So we must capture the outrage of people that is not yet articulated. An accurate social and structural analysis of the remarkable reality in Massachusetts has to address specifically all the aspects of poverty, because we have accommodated ourselves and allowed poverty to be so institutionalized that it is now much more complex. Once we do this comprehensive analysis, we need to put it into some kind of structural context. This will give us, I think, the energy required for the job at hand. Then we need to hold up the analysis against the vision and let the vision be its judge. This is, I suppose, a theological reflection. I mean, here's this reality and this is what we believe it should be. We then need to pay attention to the gap between vision and reality, letting our principles be our guide. Grounded in our common values, once our principles are designed, we can then move into another phase.

In other words, action planning comes out of the sense of calling generated by the vision and the analysis. If, for instance, we feel called upon to create some housing, rather than a shelter, in a neighborhood, one must examine and analyze the neighborhood first. Do you deal with the banks first, or the NIMBYs? (This is assuming that the NIMBYs — the Not In My Back Yard crowd — have invaded the old neighborhood and are not willing to give it back.)

All of this must flow out of the analysis, which is where we get our energy, which is both personal and passionate. But if the debate becomes an intellectual debate, we lose this quality and passion. That is why a disciplined process is so appropriate. It enables people to see how their personal instincts and their personal desires to make a difference can have an impact by working as a group. It also allows us to overcome isolation. It allows us to move from guilt to responsibility, from the personal to the social, from the anecdotal to the analytical. It can even become the basis for the beginning of a North American theology of liberation, because it is the beginning of the radicalization of the privileged.

I am not a good process person. I always want to cut straight to the chase. I have learned, however, that you do need time to think. It's like those moments of conversion: you gotta give folks new knowledge, new ways of looking at new knowledge, and new ways to address the value base. The cultural Christianity we have indulged ourselves in for so long makes us all feel good, but it must change quickly in substantive ways.

By the mid-1970s the South End had become very gentrified. In the late 1970s and early 1980s, gentrification became the neutron bomb of upgrading buildings. It

“upgraded” by emptying buildings, displacing thousands of long-term low-income residents, which began a cycle of displacement that produced homelessness in its wake. The “landed gentry” were now a new social class, one that had options for education, career, and homeownership. Along with their appearance in our cities arose the “no-class people”: homeless, optionless, and frequently newly dependent on others for human resources. The new underclass was the new homeless population and included women and their children, elderly people, young street-savvy throwaways, drug addicts, Vietnam vets, people with AIDS, and the chronically homeless, including alcoholics, ex-mental patients, and singles who exhibited bizarre behavior unacceptable in the few remaining SROs (single-room-occupancy units).

Between 1980 and 1986 in Boston, 16,000 multi-apartment units were converted to condominiums. In 1977 there were only 2,000 condos; in 1980, 6,391; in 1985, 21,557, and by 1987, 30,000 condominiums. We lost thousands of single rooms and most of the residential hotels.

Between 1982 and 1984, 80 percent of Boston apartments with rentals under \$300 a month simply disappeared, while the number renting for more than \$600 a month increased 160 percent. Obviously, if you were around in 1985 and leased an apartment for \$661, you had to have a salary of at least \$30,000. Between 1982 and 1989, Boston rents jumped 64 percent.⁵ In 1990, rents in Boston increased 6.1 percent more than those in any other metropolitan area except Washington, D.C., according to the Bureau of Labor Statistics. And that contributed to the surge of homelessness in Boston.

Residential hotels offering security, ambience, and various services from mail delivery to room and linen services were a way of life for many who did not want to maintain an apartment but did not like rooming houses. People lived in residential hotels near the medical services they required. Boston, by 1982, became one of the two highest-price rental cities in the country, with a one percent vacancy rate. One of the more chilling aspects of displacement, at least in the South End, was arson, including arson-for-profit, arson-for-displacement, arson-for-gentrification. Nothing moved people out of a neighborhood faster than the whisper of smoke and the possibility of fire. At one point, David Scondras, now a city councillor for Back Bay/Beacon Hill/Mission Hill, worked with a Fenway group of housing activists who could and did predict fire patterns. They existed in older neighborhoods that were invariably ones in which two groups “turfed” — those who refused to move and those who were invading. By the late 1970s to mid-1980s, it appeared the invaders had won. The scene was set for some questionable trends, and by the early 1980s, the “young and urban planners” arrived en masse.

Having been defeated in his second run for governor by Edward King in 1978, Michael Dukakis ran a third time in 1981 and claimed that homelessness was one of his major priorities. Human service advocates, having once felt betrayed by Dukakis with his mid-1970s cutbacks, were cautious about his return to public office, but agreed to support him. His promise to help homeless people was rapidly translated into shelters, with over 140 of them by the time he left office in 1990.

But the Massachusetts legislature still refused to look at the root causes of homelessness, which would have necessitated a complete restructuring of the welfare system and a reordering of state priorities. The so-called Massachusetts Miracle was nothing more than “Let the good times roll,” nationally and locally. Greed was in — need was out. Furthermore, Massachusetts, because of abundant high-tech rolls and

real estate escalations, never seriously challenged the federal government, the Department of Housing and Urban Development (HUD), and other government restrictions in domestic services pullouts, and ended up making up the difference. This was a real mistake but it did give some credibility to the empty "miracle." But it also, with the establishment of so many shelters and soup kitchens, Band-Aided the growing problem of poverty.

In the early 1980s, Ronald Reagan began his first term in office, and his promise of getting "government off the backs" of Americans triggered an elaborate retreat from all social services, beginning with a series of deregulations. Ultimately, as we would see, privatization would come to replace the good of the community. In eight short, brutal years, five decades of important social progress came to a grinding halt. Self-indulgence became a passport to prosperity for many. An unspoken permission was given that began with a new ethic — whatever the market would allow in the name of "free enterprise." This attitude created an atmosphere and an environment in which shelters became the new permanent housing for thousands, maybe millions, by 1985. By its refusal to build desperately needed public and low-income housing, the Reagan administration allowed the shelter society to become a shelter industry. The shame and shambles of HUD testify to Reagan's commitment to "the truly needy." The administration also assisted in the creation of millions of new poverty-stricken citizens; it allowed social Darwinism to replace social consciousness; it allowed individualism to replace community. And its fallout fell on Boston.

The need for public and affordable housing was never more apparent than during the Reagan years. Under President Jimmy Carter we got 300,000 units; under President Gerald Ford 200,000; under President Ronald Reagan 25,000. HUD, originally set up specifically for housing needs, reduced 67 percent of its budget from 1982 to 1987. Thirty-two billion dollars was removed. "They sleep on grates because — well — they like to," said Reagan of the homeless. "They go to soup kitchens not because they're hungry, but because they want a free meal."⁶

Unemployment rose. Human services were curtailed; in fact, they stopped. Banks closed. Manufacturing came to a stop. The new world order took on a new meaning, with junk bond kings, S and L bankers, Iran-scam, the contra war, the invasions of Grenada and Panama. Real estate went through the sky, jobs plummeted, the housing slump began — but too late for many. And the cost of living rose dizzily for the poor, working and middle class. Without a doubt the rising cost of the housing market was one of many contributing factors to the growing poverty problem in America. Any economic disruption can have severe consequences — a late welfare check, a layoff, an unexpected illness, an unpaid utility bill. All of these contribute to the desperate needs of a poor family or individual. And while the private economy and its inflated rental patterns created more of a need for governmental assistance, the government chose instead to remove money from the very agency designed to help public housing.

Philip Clay of MIT suggests that without a significant shift of policy in favor of affordable housing, by the year 2003 there could be 19 million homeless people in America's streets.⁷ By the mid-1980s, sheltering had become big business in America. Added to that was a new elite group of service providers, including psychiatrists, social workers, psychiatric social workers, housing and homeless specialists, teachers, market experts, vendors who contracted for state services in shelters, and a

whole host of credentialed, professional, and expensive homeless “experts” who would devise a new language, further isolating already alienated citizens. These professionals held a controlling interest in homelessness, and some would be redefining and labeling homeless people. Many of the definitions were based on their own professional criteria rather than actual economic needs of homeless people. While many homeless people require a myriad of services — related, for example, to alcoholism, mental health, and drug addiction — most were in shelters because they simply could not afford to live anywhere else, including, incidentally, their own old neighborhoods. Moreover, sheltering them is expensive. A shelter bed now costs the Massachusetts taxpayer about \$1,000 a month, an amount that includes the salaries of highly paid professionals.

This new professional pedagogy would concern itself not with the capabilities of homeless people but rather with their frailties, because the weaker they seemed to be, the more funding would be made available. These professionals would, in the course of their jobs, deliver human services, but they often ended up specializing in the custody and control and “treatment” of people who were baseline, poor, and unable to live anywhere. In the 1970s, when homelessness became a *visible* problem, the general public rushed to its victims’ aid, doing shelter shifts, writing checks, and bringing clothes and food by the carloads. Altruism was “in.” But somewhere along the line charity replaced justice, and we developed an ethic to meet the need rather than acknowledge the need for a new ethic. After all, charity is sharing what belongs to you with others, while justice is returning that which belongs to others to them. In simpler terms, charity is scraps from the table, and justice is being invited to the table itself.

Because shelters in the early eighties were becoming harder to place in many neighborhoods, particularly the gentrified ones like those in the South End, the word *transitional* became a softer euphemism. The management of poor people also increased the power of the donor — the giver of “things” — and decreased the power of the receiver. We found ourselves marching toward the management of a new class: the homeless.

Simultaneously with the emergence of the transitional concept came a new group of professionals, armed with MBA’s and MSS’s, who determined who would be eligible to move from a shelter to a “transitional” setting. This meant dealing with such things as “attitudes,” “parenting problems,” “problem solving,” “life skills,” and “life goals.” It also meant labeling and defining certain groups. As a result, this labeling became yet another barrier between those who needed help and those who were giving it. It also began to create psychic separations between people, so that there was no more equality of discourse. Even the language changed. Conversations became peppered with words like “intake.” (Whatever happened to “hello”?) This created further disorientation for those people who required help. The advocate had now become the provider, and support for shelters and transitional housing was beginning to emerge as viable moral and ethical principles. The structural conditions surrounding affordable housing were not changing. The ways to help were.

Nancy Fraser, a Chicago feminist economic theorist, tells us that in a welfare capitalist state there are three elements: the need, the interpreter of the need, and the need’s satisfactions. Invariably, the needs that get satisfied are those of the interpreter.⁸

The response to homelessness as a crisis in the eighties has developed altruism into an art form. Altruism always has meant a concern for the well-being of others. Altruism gives one a good feeling, so there is a certain degree of self-interest involved. It also, like its cousin charity, alleviates some of the suffering, but it does not necessarily change the conditions that create suffering. Justice, the Bible tells us, is a kind of sorting out of what belongs to whom and returning it to them.

For example, President George Bush and his "thousand points of light" pale in comparison to the incandescent light of radical change, a change that could eliminate the necessity of a thousand liberal candles. Moreover, George Bush — and his predecessor and their allies — *set the terms of the debate*. And in setting the terms of the debate, the debate itself becomes academic. In my view, we have the capacity but lack the political will to stop poverty, and until we reclaim the moral and ethical vision America once had, we will continue to accommodate ourselves to the unethical and immoral spoilers of America, which include many of our elected officials.

In addition, if we had the economic wherewithal to conduct one of the most expensive wars in the history of humankind during the greatest deficit this country has ever known, then we have the economy to conduct an equally expensive peace. As it stands now, if every city and state stretched itself to its fiscal limits to raise housing funds, the combined total would not fill the vacuum left by the federal government's retreat.

A New Hostility toward Homeless Populations

The number of homeless people in America has risen sharply over the last decade, reflected in the proliferation of urban shelters — up from 1,900 in 1984 to 5,400 in 1988, and over 6,000 today.⁹ People are no longer touched by homelessness, they are hostile toward it. They don't want to see homeless people lying in the streets or panhandling on street corners. You ask, Was it this bad five years ago? Ten years ago? Fifteen years ago? Why have we allowed it to continue? The latest buzzword in social science groups these days is "compassion fatigue." They seem "tired" of being kind to homeless people.

Some publications suggest that the homeless problem has four ingredients: housing, poverty, drugs, and mental illness. I disagree. The homeless problem has one major ingredient: a prearranged system of priorities that allows the government to wage war with other countries and not pay attention to its domestic problems, which in turn allows social conditions to get worse with each passing decade. According to Barry Bluestone and Bennett Harrison, the federal government deliberately engineered two deep recessions in 1980 and again in 1981–1982 through a combination of tight monetary policy and large cuts in social programs, including such entitlements as unemployment benefits, Social Security benefits, farm subsidies, food stamps, and welfare assistance. People were then forced into a labor market that actually created unemployment. As a result, both unionized and nonunionized workers had little leverage with which to demand higher wages or job benefits and often were forced into major concessions by management.¹⁰ President Reagan, in his first ten days in office, put a freeze on more than 170 pending regulations. By the mid-eighties it was painfully evident that deregulation and its soulmate, privatization, would have a significant impact on the country's economy.

But other forces were at work, too. Reckless financial speculation, marginal airline safety measures, bank failures, corporate raiders, junk bonds — the whole schmeer — were just the beginning. The doctrine of laissez-faire was being revived in America while the entire underpinnings of America's social structures were coming apart at the seams. We have reached that watershed moment. We are at a time when the institutions of our society, created in earlier centuries, are unable to meet the current crises. What we are faced with are not crises but chronic conditions. Crisis in the family, in housing, in education, in medical services, in public transportation; crisis in banking, crisis in the church, in business, in labor unions. And the problem is not regional or parochial, it is global.

The period we are living in is critical. The social service institutions set in place in America in the 1930s and 1940s are overwhelmed and cannot any longer support the growing number of citizens requiring assistance. Geographical and political changes have occurred, but the institutions are lagging. We have come to that point in our history when charity is not enough. A reordering of priorities is essential to our survival if we are to continue as part of the human race. Change must take place. But there is a natural human tendency to hang on to what one has. There are those who gain from homelessness, from poverty, from hunger. *Cui buono?* — the great lawyer's question — means "Who benefits?" As change takes place in America today, what is the direction? Who will gain? Who will lose?

Do You Give Away Fish or Teach People How to Fish?

It's cheaper to have shelters than to support a decent standard of living for every American, even though Massachusetts last year paid out over \$200 million for "programs for the homeless." Maintaining shelters is still cheaper. A federal study undertaken several years ago found that between 1960 and 1985, federal and state cash assistance programs grew 105 percent in real terms, while noncash programs for services and commodities grew 1,760 percent.¹¹ By 1985, cash income programs amounted to \$32 billion, while commodity and service programs totaled \$99.7 billion. In 1984, the share of the national income received by the wealthiest 40 percent of families in this country rose to 67.3 percent, their largest share since 1947. Correspondingly, the poorest 40 percent of all American families received 15.7 percent, their lowest percentage since 1947. During the Reagan years, the combination of spending cuts for the poor and tax cuts for the rich produced an enormous government-induced redistribution of wealth.¹² But even though the cost for homeless programs has skyrocketed, it is still cheaper than restructuring a standard of living that might prevent homelessness. For example, programs for the homeless in Massachusetts in 1983 amounted to \$9.915 million; in 1987, \$142.260 million; and by 1988 the price had soared to \$158.365 million. From 1983 to 1988, homeless programs increased by 150 percent.¹³

Hunger and Homelessness: The Roots of Poverty Are Spreading

This country virtually eliminated hunger in the 1970s, but because of federal cut-backs, the blight has returned. By a common definition of hunger, some 15 million

children and 10 million adults are hungry. By 1982, more signs of hunger were showing up; increased numbers of people were coming to churches and social service agencies because they did not have enough to eat. A number of reports, including those prepared by Dr. Larry Brown of the Harvard School of Public Health, who chaired a task force on Hunger in America, concluded that hunger had reappeared as a serious national problem. By 1985, the Physician Task Force on Hunger in America calculated that hunger afflicts some 20 million Americans.¹⁴

In 1978, I started the Boston Food Bank in an effort to deal with what seemed to be a heat or eat proposition. People in Boston were making serious choices — did they provide fuel for their families or feed them? In 1990, we distributed over 6 million pounds of food to over 700 direct feeding agencies — and it was not enough. Evidence suggests that in 1991 the problem of hunger in America had grown worse. In 1984, Second Harvest, a national network of food banks, tabulated its three-year battle against hunger: in 1981, its members distributed 15.2 million pounds of food; in 1982, 30.3 million; in 1983, 45 million, and the lines kept growing.

In a discussion of the problem, Boston Food Bank's executive director, Westy Egmont, added this bit of information: Second Harvest continued to distribute millions more as the years went on — in 1986 it was 128 million pounds; in 1987, 152 million; in 1988, 172 million; and by 1990, close to 190 million pounds.

In 1991, the Boston Food Bank distributed over 7.5 million pounds of food, and the statistics throughout the metropolitan area keep going up. Also in 1991, requests to the Springfield Salvation Army tripled; Worcester had a 300 percent increase of need; the First Baptist Church in Beverly, 100 percent more need than in the previous year. Yet all the soup kitchens in the commonwealth, plus the food banks we have established, are not stopping hunger from rising in Massachusetts. Furthermore, the 140 shelters that are state funded, and the shelters that are not state funded, have not stopped the increase of homelessness in Massachusetts. Compounding this is the fact that today we have to deal with AIDS among the homeless population, which is a larger problem than the commonwealth would have anyone believe.

Midcentury, Boston lost its manufacturing base and instead became a service industry town. But jobs in service industries, such as McDonald's and Mrs. Field's, do not pay the rent, do not pay for the groceries, do not pay for medical or educational or transportation expenses. In my opinion, Ed King, the former governor, was weak. The surpluses generated by a quick-fix economy and the technocratic liberalism of a Michael Dukakis kept the Reagan wolf from the door. Indeed, one of the myths of the Massachusetts Miracle allowed the state to shore up the federal take-away that began in the early eighties.

Governor William Weld has begun to "correct" this error by cutting all human services to ribbons, and we are now faced with an extreme ideological right-wing interpretation of how to make government work. The poor will continue to pay the highest price for the new domestic new world order being imposed on the commonwealth. In Weld's brave new world, none but the strong and the rich will survive the draconian cuts.

Part of the problem of finding a common voice, with a common goal among advocates and providers, is that we are all fighting for small pieces, rather than demanding something that makes sense for the commonwealth.

Exiling a Class of People Will Not Solve the Problems of Poverty

Walter Brueggemann, a Protestant theologian, tells us that real criticism begins with the capacity to grieve, because it is the most visceral announcement that things are not right.¹⁵ I believe we must grieve openly for the things we have allowed to happen in our good name. We have, by our silence or indifference, allowed poverty to become so institutionalized that we once again numbly accept the idea of almshouses. There is a danger in this, that we succumb to the notion that shelters are better than nothing. By imprisoning thousands of people in shelters, we exile a whole class of citizens whose rights are being taken away, even as we read this. Do we continue to implement bad policy, a policy that continues to perpetuate a brutal two-class system, or do we set the terms of the debate?

Over the years there has been a cultural and societal acceptance of sheltering that cannot be continued if we are to continue to call ourselves members of the human race. We have, by the acceptance of shelters, allowed the government and the private sector to get off the hook.

The private/public partnership, devised by the Reagan administration in the early 1980s, was a useful but sterile plan. Purportedly it was a way to work with government. But it did not change government. It supported it. It did not challenge government. It allowed it to retreat further from its domestic policy, that of caring for all Americans, particularly those so financially marginal that without government help those citizens would die.

The philanthropic community, already overburdened in the eighties, suddenly had to stop what they were doing to concentrate on housing and hunger. This is not an appropriate role for all of the philanthropic community. In my view, philanthropy should be there to enhance the quality of life. Why did the people in philanthropy accept this without challenge? In the March 5, 1982, issue of the *Wall Street Journal*, Carol Hymowitz wrote one of the first stories dealing with the Reagan welfare cuts shifting the "charity" burden to religious groups.¹⁶ President Reagan was quoted at that time as saying, "If every church and synagogue in the U.S. would average adopting 10 poor families, we could eliminate all government welfare in this country."¹⁷ Reaganomics created homelessness, and hunger, and poverty itself. Churches and the philanthropic community alone cannot make up the difference. Only the American people can turn priorities around. And now with evidence of the middle class surreptitiously wending its way to the local food banks, perhaps the time has come to remind us that we *are* our sister's sister (not her keeper), but we cannot make it by shelters and soup kitchens alone. Rather, we need a responsive government to *all* citizens' needs, not just the rich, who have truly made it in this country in the last two decades.

"The Gospel calls us to feed the hungry and we will do that," said the Reverend David Sieplinga of the Madison Square Christian Reform Church in Grand Rapids, Michigan.¹⁸ But handouts "can't replace the right of every person to a job that earns him enough to buy his own food. The goal shouldn't be replacing dependency on the government with dependency on churches."¹⁹

That soup kitchens and shelters have become fixtures in one of the wealthiest countries on earth says something about America, about Americans, and our leaders.

When everything in human services is the priority, what's the priority? The terms of the debate determine who gets what. The problem is, the disenfranchised are pitted against one another: tots fighting elders for resources; vets fighting welfare moms; the working poor against the nonworking poor; retarded people against the mentally deficient. Class against class, women against men. No wonder we can't get anywhere! When the current budget crunch began in October 1990 with Dukakis, and continued with the Weld administration, shelter providers formed a tidy alliance, but left welfare advocates out of their conversation. When we were all told that some shelters would be spared, but that 7,000 people over forty-five who were on welfare and had no reading skills would be thrown away, nobody budged an inch. Governor Weld closed off the 707s, which ended homeless prevention programs that housed previously homeless families, but now they, too, would be thrown to the wolves.

There is something wrong in our thinking, in our assessments, in our economic skills when we allow such a condition to prevail. Fundamentally, what is at stake here is quite simple: service system lobbyists and advocates see the competition for limited public resources as a competition between various service providers and systems. They rarely acknowledge, however, that the net effect of their lobbying is to limit cash income for those they call needy and increase the budget and incomes of service programs and providers. The results become a piling up of publicly funded services and a stagnation in commitments to income. Poor people need income, choice, and economic opportunity, not service, therapy, and labels.

As the power of professional and service systems ascends, the legitimacy, authority, and capacity of citizens descend. The consequence of this professional persuasion is devastating for those labeled people whose primary "need" is to be incorporated into community life, not isolated from it.

By analogy, according to Professor John McKnight at Northwestern University, in *Do No Harm*,

each individual service program is like a tree. But when enough service programs surround a person, they come to live in a forest of services. The environment is different than the neighborhood or community. And people who have to live in the service forest will act differently than those people whose lives are principally defined by neighborhood relationships. And though the residences of those living in institutions, such as shelters, are in a neighborhood, their lives are lived as in a forest.²⁰

Shelters are not homes. You cannot invite someone in for the evening. You cannot have a beer with a friend or two after 9:00 P.M.; you don't have a *key*; you have precious little privacy with your child; and you can't stay in bed in the morning if you feel like it. In your own home you can do all these things. Well, it's better than nothing, you say. I'm not so sure anymore. Shelters, even the best of them, afford you no life of your own. And well-meaning advocates build on your frailties and deficiencies instead of your capabilities.

"She has no house skills," they might say. Or no parenting skills. "She does not relate well to her children," they might say. All of this might be said at some time for all of us, and I resent the language that separates homeless people from the rest of society by virtue of the fact that they have no money to live anywhere else. Human service professionals focus on deficiencies and call them "needs," and each per-

ceived deficiency gets a label, which is probably fundable. The second structurally negative effect of the use of the human service tool is its effect on public budgets. A shelter bed should not cost \$1,000 a month. But it does now. There are choices to be made here, and I think they should be publicly debated. Beginning with the national budget, should we have more land-based bombers or more missiles? Or should we instead have more jobs and housing and education? Should we maintain a shelter (read poverty) industry or should we begin to re-create a decent standard of living for all Americans?

The terms of the debate are set by those who would profit from the conclusions. Shelters, for instance, are fundable. Housing is not. Jobs are not. Education is not. Sheltering the homeless is not going to change anything. It will shore up the institution of sheltering, however, and create jobs for a professional pedagogy in human services. It already has. No shelter should have a marketing director, but I'll bet some do.

We must make housing affordable and available. In some neighborhoods in Boston, rents have increased over 300 percent! The waiting list for Boston housing alone is over 27,000. And private housing is out of reach for a growing number of citizens. In Massachusetts we are suffering the highest rate of unemployment in almost twenty-five years. Unemployment compensation is running out for many. Housing, according to the real estate market, might have slumped, but not enough for our crowd. In fact, I would be willing to bet that most middle-class people are now paying close to 50 percent of their incomes on housing.

Expiring use — that is, developers who twenty years ago got loans from the government if they allowed a third of their housing to be used for low-income families — is now reaching a precarious position in Massachusetts as well as elsewhere. The mortgages are all paid off, and the developers can now do what they want with their property. Over 40 percent of the expiring-use mortgages in Massachusetts are in the city of Boston alone. Unless we sit down and decide what is going to happen to all of us, that light we see at the end of the tunnel might be another train!

It seems pretty simple to me, perhaps too simple. What we have to decide on is an appropriate standard of living for all citizens, and then work toward that end. This means we need to provide jobs that pay salaries that pay the rent, to create reasonable access to medical and educational resources. Is that too much to ask? Why is it that poor people have to settle for alternatives, while the rich have options? We need to set the terms of the debate again so that human resources will be a priority, not a special need.

Do we need shelters? Sure we do. It's too late not to have them now. But we also need to look at sheltering differently, just as we need to look at taxes differently. Thirty-eight states have a more progressive tax base than Massachusetts. We need to look at jobs. Fifty percent of American workers today are living perilously close to the poverty line. They're not kidding when they say, You are all living two paychecks away from disaster. All of us know what increases have meant to our paychecks. What college costs now. What apartments and housing cost now. What has happened to us is that we have lost a sense of community. We have lost a sense of the common good, and we desperately need it back again.

Young people are our greatest resource, and we are killing them by depriving them of housing, of medicine, of education, of jobs. As we speak, young kids' dreams are not only being deferred, they are being denied. Kids are finding that they

have to leave college. Babies are being born at Boston City Hospital with nutritional deficiencies that will prevent them from ever living productive lives. Young kids are killing each other over a pair of Nike sneakers. They have discovered that the shoes you wear are far more important, image-wise, than who wears them. Young people are suffering the same concerns their parents and grandparents are, because their grandmothers' and grandfathers' medical services are being taken away from them. Young people out of college can't find jobs or housing, so they are moving back with their parents, who can't afford them. And young people everywhere are dying for rich old men's profits and lust for power.

But if we are strong and passionate and committed, we can set the terms of the debate around survival. We live in a world with a lust for power that defies description. Do we need a walk for hunger? A stroll for AIDS? A fund-raiser for shelter? Sure. What we really need is a world without homelessness, without hunger, without AIDS, without war. We need a vision of how the world can be rather than an agenda based on the personal and political desires of the most powerful.

Political Theology and Public Moral Values: A Call to Conscientious Action

What is happening in Massachusetts is a microcosm of what is happening all over this country, and it is dividing us. We are alienated from each other. The haves. The have-nots. The wannabes. The privileged and the not-so-privileged. What is happening is a kind of class continuation of the war on the poor and middle class, using both groups to cancel out each other for smaller and smaller pieces of the pie. We need a realistic public policy around standards of living. Standards of ethical behavior. We need public policies around the necessities of life. Social action can change things. Social services provide only a minimal service, based on what other people think poor people should have. We need to take sides. We took sides on civil rights a long time ago. We took sides around the Vietnam War. Now we need to take sides for human rights.

Our moral vision has been usurped in hundreds of ways, and we have accommodated ourselves to a selective morality that excludes all poor people too. In Dorothee Soelle's most recent book, *The Windows of Vulnerability: A Political Spirituality*, she speaks of the theologizing of politics:

After the attack on Grenada, Robert McAfee Brown, a leading Presbyterian theologian, wrote an open letter to Christians outside of America, in which he showed how much civilian control of the military (one of our most cherished traditions) had been replaced by military control of the civilian population (one of the best tests for the beginning of a turn toward military fascism).²¹

What could be clearer to us today, after we listened to every two-bit general telling us how the war was going in the Persian Gulf? — in the name of national security — while the media acted like lapdogs, wagging their collective tails. The political debate has become militarized and, as we shall see, theologized, as well. This means the end of the liberal era and especially the end of its thesis about the secularization of society. What has been emerging for several years is the alliance of a certain kind of theological element with the extreme political right. The great revolutionary liberation movements in the Third World were repressed by coups, by

economic boycotts, by CIA plots, and, when necessary, wars. Necessary to the capitalist intent, I might add, or even to distract attention from national scandals such as public deficits, S and L scandals, HUD scandals, bank scandals, and so forth.

There are reasons for this drift toward militarism and conservatism. Our national conscience was so wounded by the loss of the Vietnam War and by the oil crisis, if you recall. But the extreme right had a steady answer for all that, demanding a political strength, not justice. Justice has already been dismissed as un-American, and it is diffused into the already polluted air. The new American chauvinism, as Soelle calls it, suggests the need for a Club 707 in which Christians are instructed to articulate their faith politically and a preoccupation with wealth and power is a religious tenet of the religious right.²² No sympathy wasted here on those who do not work, or for the lame, the blind, the old, and God knows, the crazy. In the context of Reagan and Bush's economic policies, that means no health care for all of the above. And while we're at it, no housing or jobs, either.

In *Listen America*, according to Soelle, Jerry Falwell speaks of his favorite economist, Milton Friedman, who appears this time in the role of evangelist, stating that every form of welfare aid, of solidarity with the weaker, is regarded as not only counterproductive, but also anti-biblical!²³ So, setting at liberty those who are oppressed is not a part of Jerry's biblical imperative. We need to reclaim the moral imperative as it was handed down to us by that lowly Jewish carpenter from Galilee who came into the world not to seek reform but to transform society itself. He and his raggedy little bundle of outcasts — the most despised, least listened to community of misfits in all of Judea. Were this same man on Boston Common today, rabble-rousing as he did then, we would be much kinder. No heavy wooden cross these days for such a loud mouth. A zap of Thorazine perhaps, and then pink-slipped into obscurity.

Felix Rohatyn, the investment banker and civic leader, said, "A democracy to survive must at the very least appear to be fair. This is no longer true in America."²⁴ I couldn't have said it better myself. Our time is running out. Our problems are overwhelming but not unfixable. Bad politics inspire bad public policy. We need to change that, and it begins with a personal ethic. The sixties gave us a sense of community. The seventies gave some of us a sense of altruism. The eighties gave us permission to be individuals — to "just say no" to everything that did not enhance our own power base. What will the nineties bring? Who will we be? Is that already being determined by the likes of William Weld and George Bush? I sincerely hope not.

Individualism is supported by a personal piety. The loss of community to individualism is part and parcel of the cultural Christian movement, which has had a dramatic impact on the American standard of living, as well as the government's retreat from social policy. Witness: prayer in schools, abortion, states' rights — but you cannot pray away, sing away, or bumper-sticker away poverty in America and in Boston. There is a cultural/political/social accommodation to all of this that sifts down to the most basic of human aspirations. Public (or civic) ethics demand that we take a stand. The interpretation of ethics tells us where we stand. As godless as the sixties were said to have been, people still had enough concern left to care about the destruction war creates, the necessity for civil rights and its implementation, and the need for shelter and food for all.

The Old Testament prophet Amos was right on target when he spoke of burnt offerings. Hunger and homelessness in America have reached catastrophic pro-

portions, maybe even apocalyptic proportions. The age of volunteerism and points of light have also reached gigantic proportions. Shelters and soup kitchens have become the burnt offerings of the twentieth century. I must confess that I, too, have played into the burnt-offering theory, and for a while I felt pretty good about it. But as of today there is more hunger and homelessness and hurt in America than ever before. And I have to look at that.

Last year I went on a public fast as witness, a critique of the administration that would callously dismiss from the welfare services seven thousand people, all of whom were over forty-five, most of whom were women — mothers at that — and most of whom were illiterate and had been told years before that they were unemployable. Since that threat, cutbacks have been carried out by a younger, leaner, meaner administration. I went on that fast for atonement, for what was being done to poor people in my good name as a taxpayer. I fasted for redemption, for I truly felt that redemption was not far behind if atonement was to be part of the screaming hurt, and I felt that it was my Christian mandate to bring this kind of hurt into public scrutiny. We must grieve openly, as Walter Brueggemann tells us. I began the fast for repentance, to beg the forgiveness of the poor of Boston to whom this was being done in my name as a taxpayer.

I chose the words of Amos, who had much to say about burnt offerings:

You people hate anyone who challenges injustice and speaks the whole truth in court . . . You have oppressed the poor and robbed them of their grain . . . I know how terrible your sins are and how many crimes you have committed. You persecute good men, take bribes and prevent the poor from getting justice in the courts. And so keeping quiet in such evil times is the smart thing to do.

Amos would also find it tough sledding on Boston Common today, I think. Amos went on with his tirade:

I hate your religious festivals. I cannot stand them. When you bring me burnt offerings and grain offerings, I will not accept them. Stop your noisy songs; I do not want to listen to your harps. Instead, let justice flow like a stream, and righteousness like a river that never goes dry. (Amos 5:21–24)

Harsh words to the privileged, I think. No thousand points of light for Amos, thank you. Our “burnt offerings” become alternatives to justice — shelters and soup kitchens and food banks, some of which I started myself. For the past several years I have spoken out about setting at liberty those who are oppressed. Maintenance efforts threaten to recreate the almshouses and the orphanages of the nineteenth century. The Band-Aid solutions are wreaking social havoc. We have already seen the results of raising children in the unstable and unholy and impermanent environments of shelters and welfare hotels. They not only expose our children to violence and criminal activity, but they also serve to break down traditional family roles and discipline. And they ultimately can cause mental and physical anguish that frustrates any normal development. Ah, you are probably saying, she doesn’t like social workers. I don’t dislike them. They simply haven’t changed anything, any more than I have. To continue what we are doing might perpetuate the problem, not solve it, and we have to look at that.

Physicians are asked to take the Hippocratic oath. Perhaps we should do that. Perhaps social workers, shelter workers, and all of us in human services should take

that oath to do no harm, as Professor McKnight suggests. Even reform needs reform now. And I think it begins with those of us who have tried to justify every breath we took all those years of Band-Aiding, clothing the naked, feeding the hungry, sheltering the homeless. Our world has become a vast shelter, where we maintain a particular class of people. It is time to set them and ourselves free. It is time for all shelter and hungry people to demand justice, not more funding for shelters and programs.

Ah, she's a purist, you're saying. I'm not a purist. I'm a realist. "Kip is such a pessimist," you are saying. I am, rather, an informed optimist, and I have spent the last five years working with progressive economists, who agree with me that poverty is a question of economics. Who gets what? When? And who does not? Had I known these simple truths twenty years ago, I would have spent more time demanding to be let in on the terms of the debate itself, as I believe we should be doing now. I have infinite hope that we can make it, you and I, through that dark and lonely night together. One voice. One common vision. One goal. One vision, not a menu of funding agendas.

But even in my rage, I continue to offer burnt offerings. For the past year I have been working with a group of women I admire. We have started raising funds for homeless women who have AIDS. We call our house "Ruah," which is Hebrew for "a breath of life." Just as over seventeen years ago I watched women passing as men to get a meal, I am now watching homeless women living with AIDS whose realities are denied daily by human service workers in the welfare departments and in Social Security offices. "They're not sick enough" is the customary answer. We have a lot to learn about compassion. And need. Whose needs are being met when we tell them they are not sick enough?

The political theology by which I try to live my life is not particularly comfortable. It is a matter of consistent reflection. *Cui buono?* Who benefits? It is not easy to try to find my own tangled spiritual roots. I find I must step back into history and try to remember that carpenter who listened to those whose realities were being created for *them* by those in power. To those of us on the urban scene, a frightening and devastating landscape, we must continue to allow ourselves to be evangelized by the poor, the misfits, the disillusioned, the disaffected — and yes, the disappeared. We in the city politic see the forces of evil and power colliding in the rawest of forms. We have the opportunity to challenge this force, this rawness, this evil. We have the rare and sacred opportunity to see the faces of the poor, over and over again, in the frightened, sad, empty, disillusioned eyes of the young, the old, the lame, the blind, and God knows, the crazy.

The city is living history and is located at the intersection of all cultural and historic forces. It is here, at the core, that the strength or weakness of any society is most accurately measured. It is here, at the core, where unnumbered human souls will be sacrificed. And it is here, at the core, where one discovers that history is created if not by the spiritually mature, then by the spiritually depraved and degenerate. And finally, it is here, at the core, where prayerful hands become clenched fists and the presence of God is most discernible in rage. I have this rage. I have this hope, that we will have the source and faith to reclaim the moral vision, and our goal is not necessarily to obtain eternal life, but life now. The goals we set for ourselves and our little bundle of raggedy outcasts is to transform society together, today. So that there will be a tomorrow for all the disenfranchised of Boston.

We Must Ask the Right Questions to Find Answers

Dan Berrigan, in the foreword to Hombs and Snyder's *Homelessness: A Forced March to Nowhere*:

What of the system, the web? The system does not strike at random, strike only once; it is a trip hammer, nicely calibrated to deliver repeated blows, death by the hour, the day, the lifetime. But what fuels so horrid an engine? Who devised it? And how to dismantle it? And finally, what to put in its place? The persistence of evil; that is the first understanding, and then to counter with a persistent goodness, a life of active virtue, a community in which it is less difficult to be holy; as a sign of a holy future, available to all. Meantime, a faith that does not give up. This, I take it, is nearly the best we can do in a time when almost everyone, in one way or another, gives up.²⁵

Dearest Dan: I couldn't have said it better myself! We must never give up!

All of us have agreed to write for this journal out of a sense of hope. We appear here at your invitation, not because we find some answers, but because we may find some new questions together. We are all here because we care, because we love, because we continue to hope against all possible odds. Because we dream, because we must find a common goal, a common ethic, a common moral, by which we can live our lives as successful members of the human race. Without that common vision, we are alone, all of us. But with it, we will move mountains. We will fulfill the promise of Amos, and we will let justice flow like a stream, and righteousness like a river that will never run dry. 🐼

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A Visit to the Vet Hospital

D.B.

The vets ran the hospital.
They wore their scars proudly
like LBJ.
He's dead now.
They're living in hospitals
Running wards.
He wears long hair
and a beard.
He probably hated
hippies
and went to Vietnam
of course.
There are Indochinese girls
working on the ward.
It's American to forget
and
accept other races
Happy Independence Day
I'm locked up in a Vet hospital
No freedom to leave
They let Matilda Bardahl
leave

She cut up her arm
Hit her boyfriend
with a baseball bat
and
wants to make a deal
to have an abortion
so she can get married
She was released
not me
I like to write poetry
get drunk and high
and
said I might hurt myself
if I drank for two weeks
but maybe not
So
Why the fuck am I
here
on Independence Day

D.B. is a member of the Portland (Maine) Coalition for the Psychiatrically Disabled. His poem first appeared in The Portland Coalition Advocate. Reprinted with permission.

The New England Shelter for Homeless Veterans

A Unique Approach

Ken Smith
James M. Yates

It has been estimated that veterans comprise one third of the homeless population. To combat this national disgrace, many small veterans' groups have been formed nationwide to serve their homeless "brothers" in such settings as shelters, group homes, and outreach centers.

A Boston group, the Vietnam Veterans Workshop, based its New England Shelter for Homeless Veterans on the simple but powerful concept of veteran helping veteran. The shelter created a program to accomplish three important functions: providing the basic necessities of a bed, a meal, clothing, and a hot shower; rehabilitating the veterans by offering various activities to comfort and motivate each one to take positive steps in life; and finally, healing the veterans who still feel the effects of their war experiences by designing a program to address the needs of those suffering from posttraumatic stress disorder.

At the conclusion of Oliver Stone's Academy Award-winning film *Platoon*, the main character, played by Charlie Sheen, delivered a heartfelt soliloquy. As a helicopter carried him away from the fighting that had made his tour in Vietnam such a terrible and memorable experience, he looked toward the future: "Those of us who did make it have an obligation to build again. To teach others what we know, and try, with what's left of our lives, to find a goodness and a meaning to this life."¹

This challenge to Vietnam veterans has been taken up by a Boston group, the Vietnam Veterans Workshop, which has concentrated on finding innovative and effective ways to fight homelessness in the veteran community. To this end, the workshop founded the New England Shelter for Homeless Veterans, specifically targeting the veterans who are part of the homeless population. In this article we examine the problem of homelessness in the veteran community, then tell what is being done throughout the country to fight this national disgrace. Finally, we turn our attention to the Vietnam Veterans Workshop to share the methods and programs we have devised to serve and rehabilitate homeless veterans.

Ken Smith, executive director of the New England Shelter for Homeless Veterans, is president of the Vietnam Veterans Workshop and chairman of the National Coalition of Homeless Veteran Service Providers. James M. Yates, an employee at the New England Shelter for Homeless Veterans, is program manager of its Computer Training Program and veterans' liaison to veterans organizations throughout New England.

The Problem

Studies in the mid- to late-1980s estimated that veterans comprise one third of the homeless population.² According to the U.S. government, there are approximately 150,000 to 250,000 homeless veterans throughout the country "on any given night."³ Men and women who once served and fought for this country are homeless! While these statistics are shocking, they correspond roughly to the percentage of veterans in the entire population (32%).⁴ In just over a year, the New England Shelter for Homeless Veterans alone has served more than 1,600 veterans at its downtown Boston site. Although the heaviest concentrations are found in urban areas, homeless veterans can also be found in rural and suburban areas in every state of the union.⁵ The depth and extent of the problem of homeless veterans more than justifies the need for a national policy to address this issue.

Veterans, like others, are homeless because of a variety of factors, such as lack of affordable housing, unemployment or underemployment, chemical dependency, health problems, and mental illness. Homeless veterans are largely no different from the rest of the homeless population. Most have gone through a series of hardships and been affected by many elements that contribute to their homelessness. Although common experiences can cause people's homelessness, there is one major difference between homeless veterans and the rest of the homeless: the homeless veterans' records of service and sacrifice in defense of their country. America must respect the veterans' contributions. As stated in a *Boston Globe* editorial, "It is a travesty that any American should be forced to live in the street; it is a travesty and an insult when those who have fought our country's wars are forced to do so."⁶ The federal government has a responsibility and obligation to create a national program for homeless veterans in recognition of their service.

One factor leading to homelessness that specifically concerns many veterans is the lingering effect of their combat experiences on their psyches. Posttraumatic stress disorder (PTSD) is most likely to affect Vietnam veterans, many of whom have never become reconciled to their military service in an unpopular war. Symptoms of this condition include depression, isolation, rage, avoidance of feelings (alienation), survival guilt, anxiety reactions, sleep disturbances, nightmares, and intrusive thoughts.⁷ According to the National Coalition for the Homeless, Vietnam veterans with PTSD are particularly prone to becoming homeless at some point in their lives.⁸ Although this condition can be treated through group counseling and individual therapy, it is difficult to provide outreach and assistance to homeless veterans. Many are alienated by the Veterans Administration and its programs. (Its official designation has been changed to Department of Veterans Affairs, but the agency is still referred to as the VA.) Most have no other avenue to find help in dealing with PTSD.

An Emerging National Issue

Increased concern for veterans of previous wars, especially Vietnam, followed Operation Desert Storm. Although some disagreed with the decision to go to war, support for the troops in the Gulf was always strong. The American public had finally separated the warrior from the war, which was not done during the Vietnam War. Many tried to use this occasion to give Vietnam veterans a proper welcome home, which they had never received. This attempt by people to reconcile their feelings

about the Vietnam War was good for the nation and especially for those who fought in it. Amid this friendly environment, signs of a national movement are becoming evident.

In the past few years, many small veterans groups have concentrated their efforts on the plight of the homeless veteran. Attacking the problem in many innovative and different ways, they organize and run shelters, group homes, and centers catering exclusively to veterans and their needs. The National Coalition of Homeless Veteran Service Providers, formed in April 1991, has members in thirty-nine cities across the country. According to Bill Elmore of the Vietnam Veterans Leadership Program in St. Louis, "Just as the G.I. Bill preceded other student loan programs, these programs could presage a broader national effort."⁹ With the national support of Desert Storm veterans still apparent and the success of direct service ventures, the coalition may be able to force the federal government to give the issue of homeless veterans the priority it should have.

In addition to the work of the Vietnam Veterans Workshop in the Greater Boston area, many innovative programs serve homeless veterans. One of the most creative and successful is Standdown, a project designed by the Vietnam Veterans of San Diego. Once a year, for three days, a host of public and private agencies meet in an encampment to provide services to San Diego-area homeless veterans. The services deal extensively with every concern they may have, including medical examinations, legal counseling, employment counseling, social services (both state and federal agencies), substance-abuse programs, veterans benefits counseling from the VA, mental health counseling, food, and clothing. More than seven hundred homeless veterans participated in Standdown 1991. Robert Van Keuren, the organizer of this event, is exploring the possibility of replicating the project in different communities throughout the country. The meeting is especially intriguing because it reaches a large number of homeless veterans at relatively moderate costs.

The issue of homeless veterans gained additional support on Veterans Day 1991 with the release of a report by the National Coalition for the Homeless, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States*. Using statistics from public and private sources to support its claims, the report declared the issue to be a national problem. Backed by data from the three federal programs that specifically target homeless veterans, the Homeless Chronically Mentally Ill program, the Domiciliary Care for the Homeless Veteran, and the Homeless Veterans Reintegration Project, the report also gave us the first national demographic profile of the homeless veteran population. A few interesting facts surfaced. First, a large percentage of homeless veterans are better educated than the general homeless population (over 80 percent graduated from high school, with one-third having either attended or graduated from college).¹⁰ Second, the majority have been homeless for less than one year.¹¹ In addition, veterans who served during the Vietnam era (1964–1975) make up approximately 40 to 60 percent of the population.¹² Although the Veterans Workshop maintains data only on the veterans' era of service (as of December 23, 1991, Vietnam veterans made up close to 51 percent of those the shelter has served), it has been our experience that these findings are consistent with the veterans who come to the shelter. Finally, the report criticized the federal government's response to the problem of homeless veterans as "shamefully inadequate."¹³ This report proves that the problem is one of national proportion, requiring an adequate and responsible response from federal authorities.

Veteran Helping Veteran: A Powerful Philosophy

Although the workshop believes that increased federal funding is needed to serve the entire homeless veteran population adequately, it doesn't see government aid as the panacea to the national problem of homeless veterans. Instead, the real strength lies within the veteran community itself and the natural bond of brotherhood is present in this community. The simple concept of "veteran helping veteran," on which our shelter is based, really does work. The shelter has received tremendous support from veterans organizations throughout Massachusetts. From the Veterans of Foreign Wars to the Disabled American Veterans and from the American Legion to the AMVETS, each organization has done its part in aiding brother veterans in need. With the homeless veteran emerging as a national issue, we hope that the national offices of these major veterans organizations will adopt this issue as one of their own. Should these national support groups stand solidly behind the issue and the direct service providers who serve the homeless veteran, their volunteer efforts would do more to aid the cause than any increase in federal funding. The veterans organizations have responded to the homeless veterans' calls for assistance at the local level throughout Massachusetts and in other parts of the country. All that is needed is leadership at the national level to adopt, actively lobby, and support the issue of the homeless veteran.

The Vietnam Veterans Workshop

The veteran helping veteran philosophy was born in a combat support group at the Brighton Veterans Outreach Center. In 1986, several Vietnam veterans began meeting to discuss issues common to them. They became aware that they were not alone, that others had similar feelings about Vietnam, about coming home, about life. They began to help themselves with the transition to life after Vietnam. In 1988, members of the combat support group left the veterans center to incorporate the Vietnam Veterans Workshop, a nonprofit, veterans support and advocacy group. After seeing the power of the veteran helping veteran theme in their group, they were eager to create a service group designed to help other veterans. On a visit to the Vietnam War Memorial in Washington, members of the group discovered veterans living in the park near "the Wall" and began to talk to them. The workshop members were horrified by the stories they heard and what they saw in our nation's capital. Returning from the trip, the workshop members were astonished to learn that one third of America's homeless are veterans. They immediately decided to commit themselves to this issue. Traveling to Boston-area shelters in search of homeless veterans, they were again amazed at the number they found. During one meeting at Pine Street Inn, a workshop member announced at dinner that he was planning to hold a discussion of benefits with any interested veterans. Expecting to attract fifty veterans at most, he spoke instead to over two hundred regarding their benefits. The size of the problem prompted the workshop to think in terms of acquiring its own facility to serve the homeless veteran.

Sketches of War

In 1988, the workshop was able to recruit Pulitzer Prize-winning playwright and local area resident David Mamet to create and direct *Sketches of War*, a one-night

theatrical event held at Boston's Colonial Theatre. The production featured an impressive cast, including such stars as Al Pacino, Michael J. Fox, and Donald Sutherland. The show featured vignettes of war and the experiences of the soldiers who fought in them throughout history. Excerpts included an act from Shakespeare, part of the David Rabe play *The Basic Training of Pavlo Hummel*, and poetry by Vietnam veterans. In addition to being a high-profile event that directed substantial media attention to homeless veterans, the production raised \$250,000. Part of the proceeds were given to Boston-area shelters in the form of grants to benefit homeless veterans. The remaining funds were used to produce and air a national public service announcement, "I Don't Know, but I Believe." Narrated by Walter Cronkite, the announcement was designed to raise national awareness of homeless veterans. The next step was to become part of the solution by acquiring a facility and starting a direct service project exclusively for homeless veterans.

17 Court Street

After several months of a complex application process, with much needed assistance from concerned friends, the Vietnam Veterans Workshop was able to acquire a ten-year lease on the former Veterans Administration Outpatient Hospital at 17 Court Street in downtown Boston. The building is leased by the General Service Administration as part of the Federal Surplus Property Program created by Title V of the McKinney Homeless Act, which provides surplus government property to nonprofit organizations serving the homeless. This 140,000-square-foot, ten-story building offers the potential to provide the variety of services that the workshop intends to offer homeless veterans. In December 1989, the workshop opened a drop-in day shelter for homeless veterans. The original program provided a range of services such as hot showers and meals, drug and alcohol counseling, and job counseling and referral services. A month later, Massachusetts provided the necessary funds to operate a hundred-bed emergency shelter. After the night program was added, the workshop named Massachusetts's first veterans shelter, the New England Shelter for Homeless Veterans. The workshop didn't want to limit itself to serving only those in the Greater Boston area, choosing instead to work aggressively toward providing outreach and services to homeless veterans in five New England states. Initially, staff from the city of Boston's Long Island Shelter operated the night program.

142nd Point of Light

On May 14, 1990, in recognition of its efforts on behalf of homeless veterans, President George Bush named the Vietnam Veterans Workshop the nation's 142nd Point of Light. This national notice provided the workshop and the shelter with positive publicity, and aided in underlining the tragedy of homeless veterans. The honor meant a great deal to the members of the workshop, strengthening their resolve to provide a model program to address the needs of homeless veterans. After a year of training with the Long Island Shelter staff, designed to ease its members into the difficult task of running a homeless shelter, the workshop took complete control of the site in December 1990, managing both the day and night programs at the New England Shelter for Homeless Veterans. With the building theirs, the workshop members had to develop a program and a philosophy more suited to veterans and the idea of veteran helping veteran.

The Veterans Shelter

A Unique Approach

The veteran helping veteran concept has flourished in the larger environment of the hundred-bed shelter. Recognizing that most homeless individuals lack any type of structure in their lives, the workshop wanted to create an environment that would build self-respect and self-confidence in homeless veterans. Using the military regimen with which all veterans are familiar, the workshop created a program that organizes the residents into four platoons and one company. Each platoon, consisting of twenty-five veterans, is led by a staff counselor "platoon leader" (a fellow veteran), who daily addresses the individual needs of the platoon. Whether the issue is substance abuse, a family problem, or an overnight pass, the platoon leader acts directly to aid the veteran. The program utilizes military terms in all spheres of the operation (for example, referring to clothing and other essentials as "supply") to emphasize the fact that this is a community or "place" designed exclusively for veterans. Along with these signs of military structure, the veterans sleep in bunks acquired from the U.S. Air Force arranged in a barracks-style setting.

To obtain and keep a locker, a veteran must agree to give sixteen hours of volunteer time per month. This program, administered by a volunteer coordinator, allows veterans to volunteer inside the shelter or out in the community in such groups as the Boston Food Bank and the Special Olympics. This policy accomplishes four specific functions. First, it drastically reduces the funds needed to operate the shelter. The departments of Housekeeping, Food Service, and Supply depend heavily on volunteer help to accomplish their work. Second, it fosters a sense of responsibility in veterans to give something back to the shelter or their community. Third, it gives the veterans a place to store personal items, fostering a greater sense of identity and self-confidence. With a locker, the veteran can build a wardrobe and hold personal items. Fourth, through volunteer work the veteran develops a sense of belonging and commitment to the shelter. It is not uncommon for veterans to contribute more than one hundred hours of time a month. Such volunteers of extraordinary amounts of time are often recognized for their service with free tickets to movies or sporting events. This type of commitment to the organization and its ideals has been a source of great strength for the shelter since its inception.

A veteran who first enters the shelter is individually oriented through the intake process, which is designed to identify the veteran, establishing who he or she is, inform him or her of the various services that the shelter offers, and welcome him or her to the shelter, making the veteran feel comfortable in the new environment. The shelter's day program provides the majority of the supportive services. The night program consists mainly of making its hundred beds available. Due to the lack of appropriate facilities, women veterans cannot participate in the night program. They are, however, encouraged to take advantage of all aspects of the daytime schedule.

At the beginning of the intake process, a staff member asks the individual to provide proof of veteran status. The shelter requires the veteran's DD 214 (military discharge record) and another form of identification. If a veteran does not possess the DD 214, the intake staff refers him or her to the Massachusetts War Records office (if the veteran entered the military in Boston) or requests the DD 214 from the National Personnel Records Center in St. Louis (if the veteran entered the military elsewhere). The workshop was instrumental in establishing a facsimile request

system with St. Louis, which gave homeless veterans priority status and drastically cut the response time. Because of this system, the workshop and other veterans organizations can provide better and more responsive service to the homeless veteran. A veteran who can furnish other proof of veteran status (for example, a VA medical card) and has filled out a request for his or her DD 214, is accepted on a temporary basis until the record is received from St. Louis. These precautions have been instituted to ensure that the shelter's services are reaching their intended clientele, homeless veterans.

The veteran is then asked to fill out an intake form, a questionnaire detailing his or her military record, employment status, housing status, and medical condition. The veteran receives a file number, and his or her intake information is entered into the computer used by the counseling staff to track the veteran's progress during his or her time in the program. This information is kept confidential, to be used only by the counseling staff on the veteran's behalf. After being assigned a number, the veteran is given a personal tour of the shelter facility by the intake staff member and is made to feel comfortable with the shelter so that he or she may take advantage of its services. Finally, the veteran is given the workshop ID card necessary to use of the shelter services. The intake process is designed to restore the person's identity. The homeless veteran is no longer a faceless member of the homeless population, but a member of the Veterans Workshop. The veteran is part of a community, part of a brotherhood (staff and clients frequently refer to one another as brothers), part of a place called the Veterans Shelter.

The workshop, wanting to establish the rehabilitation philosophy of the program, resisted the trap into which many large shelters fall — that of warehousing the homeless. It didn't want to become an "enabler" to homeless veterans. Instead, it wanted to provide as many services as possible to give veterans every opportunity to return to the mainstream. In keeping with this philosophy, the workshop adopted a policy that requires each veteran, within twenty-one days after securing a permanent bed in the night program, to find part-time employment for a minimum of twenty-four hours per week, or to enroll in an educational program, either vocational or academic. A veteran who does not satisfy this requirement must relinquish his bed to a fellow veteran and return to the waiting list. This policy requires the veteran to take positive and constructive measures to improve his life. The workshop expects much from the veteran in terms of helping himself, but the program also caters to the veteran, making it as easy as possible to work at improving the quality of his life. For example, the shelter allows all veterans to sleep in until noon on Sundays so that those who put in a lot of time at work or school can catch up on sleep before beginning another week. Veterans who comply with the twenty-one-day policy and remain productive are free to stay as long as it takes for them to reach self-sufficiency.

Creating a Sense of Place

In addition to its military structure, the workshop wanted to create a strong sense of place or community in the shelter. In their outreach work at various shelters, members were struck by the impersonal, dreary nature of these programs. The environments were filled with despair, pain, fear, and hopelessness. The workshop was determined to create a unique place for veterans that emphasized positive action, brotherhood, self-help, and hope.

The initial step in creating a sense of place was to make the veteran completely comfortable with his or her environment. To achieve this goal, the workshop com-

mitted itself to four objectives. First, the shelter had to be physically safe for all who use the facility. Many homeless people have stopped frequenting some shelters because the staffs could not guarantee a safe atmosphere. To maintain a safe environment, the workshop relied on its own security force, nicknamed the Bulldogs, comprised completely of former residents. As a result, the shelter is the only one in Boston that doesn't require a city police officer to assure nightly security.

Second, the shelter maintains a drug- and alcohol-free environment. If a veteran refuses assistance from the substance-abuse counselor, arrangements are made by the staff to find him shelter elsewhere. A veteran "under the influence" is never allowed to stay at the shelter. A large percentage of the shelter's population are dealing positively with their sobriety, so it is not fair to have them exposed to an intoxicated person. A veteran who enters the facility under the influence of either drugs or alcohol is referred to the shelter's Substance Abuse Department. There, the veteran decides whether or not to receive help in the form of counseling or detoxification. The workshop wanted to create and maintain an atmosphere that rewards and encourages sobriety and discourages abuse.

Third, the shelter provides a physically clean environment. Individuals are responsible and made accountable for their personal hygiene in addition to making their beds. Under the direction of the housekeeping staff, the facility is cleaned twice daily by the veterans. Fourth, brotherhood among fellow veterans is fostered and encouraged by the shelter staff. The vast majority of the staff are veterans, and approximately 75 percent of them are formerly homeless veterans. As veterans, the staff sincerely believe in the program and the veteran helping veteran concept and support and practice it in their work. Moreover, the staff participate in weekly meetings designed to create and build a team within the staff and improve the overall effectiveness of the service they provide.

In addition to creating a comfortable environment, the workshop built a sense of place by establishing innovative activities uncharacteristic of a homeless shelter. On Monday evenings, the entire shelter community meet for a unique event called Town Meeting, used primarily as an open forum for all veterans of the shelter. Staff make announcements as needed, policy changes are announced, disputes between veterans are raised and settled, guest speakers are invited to talk about issues concerning veterans, for example, AIDS, education, and employment opportunities. Moderated by the executive director, Town Meeting gives every veteran the opportunity to voice his opinion or make a suggestion concerning the program.

Through the positive use of athletics, the shelter has fostered unity and camaraderie by maintaining active basketball and softball teams. Composed of staff and residents, these teams play and challenge teams from local Veterans Administration hospitals and other community groups. Attracting young veterans, these teams give many the physical outlet necessary to maintain a positive outlook on life. The teams also provide a perfect opportunity for staff and residents to interact and enjoy one another's company in a nonshelter environment.

Finally, the shelter maintains an honor guard, which represents both the shelter and the workshop. During the last year, the honor guard proudly marched in several parades in the Greater Boston area. The highlight of the season came when they received a trophy for their performance in the Dorchester Day parade. Also composed of staff and residents, the honor guard provides a unique opportunity for the veterans to march while representing the shelter with pride and dignity. Throughout

the parade season, the shelter's honor guard consistently received a gracious and warm reception from the crowds, which acted as positive therapy to many of them toward continuing on their road to recovery. These three unique and innovative activities contribute positively to the sense of place.

After creating the community, the workshop began to ask, What should this place do? What services should this place offer? The workshop came up with three functions. First and foremost, the shelter must be a place that serves veterans. Second, it must be a place that rehabilitates veterans. Third, it must be a place that heals veterans.

A Place That Serves Veterans

The workshop's initial concern was to provide the basic services of a bed, a meal, clothing, and a hot shower. After that was accomplished, the workshop looked for different ways in which the shelter could better serve veterans. In addition to providing breakfast, lunch, and dinner daily to over one hundred veterans, Food Service provides two services that are unique to the shelter and contribute to the feeling of place. A steak dinner is served to all new residents on their first Saturday night in the shelter. This contributes to the sense that he belongs in this place. Food Service also cooks to order a hot breakfast for the veterans every Sunday morning. This, along with being able to sleep late that day, contributes to making Sunday a true day of rest. Food Service also operates a coffee counter, appropriately named the Dry Dock. When supplies are available, coffee and doughnuts are served to the veteran. The Dry Dock also acts as a popular place to congregate and socialize with fellow veterans during the day or evening.

The shelter's supply operation provides clothing and toiletries to the veteran population. The department sorts, cleans, and labels all in-kind donations. Clothing is displayed by item and size. Their selections from Supply are recorded and monitored to discourage the veterans from abusing the privilege of the system. Supply can provide veterans who are leaving the shelter for other housing necessities like dishes, furniture, and appliances. Although Supply holds an unglamorous position in the shelter, its role is essential to make available to our veterans the goods they need to continue on the road to recovery.

The shelter's medical program offers essential services to the veterans. First, the medical staff oversees and monitors the taking of all medication by shelter residents. A member of the medical staff is on duty during the shelter's second shift (4:00 P.M. to 12 A.M.) nightly. The medical staff also monitors the physical condition of the shelter population, identifying veterans in poor health they should watch individually. The staff maintains medical records on each veteran and is responsible for educating the veterans about certain health issues. In the past, guest speakers have addressed shelter residents on the issues of AIDS, tuberculosis, and high blood pressure. The medical program has sponsored TB testing, flu shots, and blood pressure screening for the population.

The workshop has created two exciting cooperatives that have improved the medical care of veterans at the shelter. Volunteer physicians and nurses from the Harvard Community Health Plan come in once a week to treat the veterans. Most of them have no health insurance and many do not qualify for medical benefits through the VA, so this weekly visit by a physician provides a much needed service. The New England School of Optometry operates an eye clinic in the shelter, in a partnership that provides exams,

glasses, and follow-up visits to the veterans at no charge. The students are able to practice and gain valuable experience in their chosen profession on a large diverse population. The veterans are provided with eye care that in some cases can change their outlook on life both physically in terms of better vision and psychologically in increased self-confidence. All parties benefit in some way from these cooperatives.

Besides the necessities of Food Service, Supply, and the medical program, the workshop has pioneered services that make life more comfortable for the veterans while they concentrate on getting back on their feet. A laundry facility allows veterans to keep their clothing clean at no expense. In another successful venture, students of the Bojack Hair School come in bimonthly to cut the veterans' hair in the shelter's own barber shop. The service is free, and a haircut gives the veterans pride in their appearance and new hope for the future. A mail facility was constructed to give each resident his own post office box. This system allows the veteran to reestablish a mailing address and provides him with a sense of identity. The shelter's van and bus provide transportation for veterans with educational and medical appointments. The shelter works at providing entertainment to the veteran, offering television and movies nightly and arranging for comedians and musical acts to come by periodically to entertain. Supplementing its softball and basketball teams, the shelter plans to emphasize physical fitness among the veterans more in the future. While in the past, the veterans have utilized facilities at the Cambridge YMCA free of charge, the shelter is currently designing an in-house training facility that will allow veterans to lift weights, ride a stationary bike, and run on a treadmill. These are ancillary but necessary to provide comprehensive services to homeless veterans.

A Place That Rehabilitates Veterans

To give veterans every opportunity to begin a process of rehabilitation, the workshop has designed a place that offers a wide range of programs and services through the following departments: Counseling Services, Substance Abuse, Job Training/Job Placement, and Housing. Each department contributes a different service for the rehabilitative process.

The Counseling Services office deals with a number of issues. The staff is responsible for administering the legal aid program that provides free legal counsel to veterans. The lawyers are all veterans who volunteer their time and services to the shelter. Many veterans have resolved a legal issue before taking any rehabilitative steps. This program allows them that opportunity on a pro bono basis. Second, the staff provides veterans benefits counseling, dealing with benefits on the local (city of Boston), state (Massachusetts), and federal (Department of Veterans Affairs) levels. The counselors, who are knowledgeable about the VA system, inform and guide the veterans through the governmental process. Veterans benefits are crucial to many, who may be eligible for financial assistance to enable them to recover from personal debt or gain self-confidence. The staff of counselors individually ensure that the veterans are receiving their rightful due. VA representatives periodically come to the shelter to answer questions regarding VA benefits or claims.

Third, the Counseling staff are responsible for referring veterans interested in educational opportunities. The shelter is privileged to be able to utilize the outstanding educational program of the University of Massachusetts at Boston's Veterans Upward Bound Program, which is specifically designed for veterans preparing to

enter college. Geared toward individuals who have been away from education for a period of time, this program couldn't present a better fit for the types of veterans who are interested in education. In 1991, seventeen veterans from the shelter graduated from the Upward Bound Program. A little more than one percent of the 1,643 veteran population served by the shelter have graduated from the preparatory program. Of the seventeen graduates, eight are pursuing an undergraduate degree at UMass/Boston. The shelter does everything in its power to encourage and assist veterans whose goal is an education. A study hall where veterans can do their homework is available. Students have access to computers on a priority basis. During semesters, the shelter runs a shuttle to UMass each night to make the commute manageable for the veterans.

Fourth, the Counseling staff provides individual and group counseling on marriage and family problems, stress reduction classes, and posttraumatic stress disorder. The most important aspect of their work, individual counseling, brings veterans home to meet and deal with difficult issues. From this point, the veterans can face their problems head-on and begin the rehabilitative process.

According to the National Coalition for the Homeless report, approximately half of homeless veterans have a substance-abuse problem. The report goes on to state that homeless veterans tend to abuse alcohol more than illegal drugs.¹⁴ Other studies show that only one third of the entire homeless population are substance abusers.¹⁵ Why do homeless veterans have such a high incidence of substance abuse? There are no clear or obvious answers. The Substance Abuse office deals solely with the issue of drug and alcohol abuse in the shelter population. Each veteran who is recognized as having a substance-abuse problem must sign a contract that outlines a recovery plan which includes participation in a specified number of Alcoholics Anonymous (AA) or Narcotics Anonymous (NA) meetings or individual counseling sessions per week. The veteran must follow this program in order to remain a resident of the shelter.

The tracking and monitoring of each contracted veteran is one of the main duties of the Substance Abuse staff, who also organize and run nightly AA and periodic NA meetings. The staff administer a highly structured, regimented substance-abuse program, which is necessary to rehabilitate veterans with a long history of substance abuse. Finally, the Substance Abuse staff handle detoxification and long-term recovery program referrals for the veterans of the shelter. The staff's main priority is to provide veterans with the best medical care possible, depending on their insurance coverage and financial situation. After a veteran is accepted to a detox, the staff monitor his or her progress and make arrangements for the person's return to the shelter after completion of the program. The staff realize that relapse is part of recovery for a substance abuser. They retain loyalty and faith in all veterans, reintroducing them to the same structured program from which they initially broke. Because drug addiction is a disease, effective treatment must be structured, intensive, and individually designed for each patient. The shelter's substance-abuse program works with the individuals to deal positively and comprehensively with their addictions in order to rehabilitate the veterans and create the structural foundation necessary to a sober life.

After the veterans have resolved their personal problems through the Counseling and Substance Abuse offices, they are referred to the internal Job Training/Job Placement Department. In May 1991, the U.S. Department of Labor (DOL) funded a \$145,000 program to create an in-house employment training and placement pro-

gram designed specifically to target homeless veterans. As part of the job-training program, the shelter has hired several homeless veterans as live-in staff in transitional positions. Not meant to provide permanent employment, these positions are designed to act as a stepping-stone to life after the shelter. These veterans receive room and board and a salary. They are trained and employed as apprentices in housekeeping, engineering, or security.

The security force is made up entirely of formerly homeless veterans. They take classes in proper security procedure, radio procedure, first aid, and self-defense. The classes are taught by another formerly homeless veteran who graduated from the Foxboro Police Academy to prepare to manage this part of the job-training program. After completing the program and accumulating a specified number of hours on security, the veterans receive a certificate of training and are qualified to act as security guard in a number of industries. Our job-placement coordinator works to secure employment for them with local Boston companies. Throughout the training, the veterans are not just provided a skill, they are given a sense of accomplishment and achievement by successfully completing the course. This self-confidence will benefit them in today's competitive job market.

The second aspect of the job-training program is the creation of a computer training lab aptly named the Computer Factory, which contains five IBM-compatible computers and two printers. The program is divided into two projects with different objectives. First, basic computer literacy classes, taught by volunteers from the business community, are designed for veterans who want to learn a little about computers and overcome their initial fear of them. Basic courses are provided in Introduction to the PC, Word-Perfect 5.1, Lotus 1-2-3, and dBase IV. The classes meet twice a week for a total of approximately six hours. After finishing one of these courses, a veteran is aware of what the software package is capable of doing and knows how to perform basic tasks and operations. The courses are not designed to develop computer proficiency, but to aid veterans who want to use a computer occasionally to type a letter or résumé. More than thirty veterans are enrolled in these classes at the shelter.

The second project is the development of a computer training program to make veterans proficient in the computer industry. Standard software for word processing, spreadsheets, and databases gives them the ability to type a minimum of fifty words per minute, and prepare them for the business environment through seminars conducted by local business executives. This project is designed for veterans who express an interest in developing computer skills necessary to the business environment. It will be considered a school program by the shelter and require a commitment to complete the curriculum adequately. Prior to entering the program veterans will have to sign an educational contract with the program director to demonstrate their commitment. A volunteer committee of computer professionals and educators, recruited with the assistance of the Boston Computer Society's Non-Profit Assistance Program, was formed to advise the program director in creating a detailed lesson plan and curriculum for the course. This program will resemble a vocational technical school curriculum in structure and content. The course will meet five times a week, five hours a day, for approximately three months. It will be divided into three sections, each with competencies that the veterans must pass before proceeding to the next level. At the successful conclusion of this intensive course, veterans will receive a certificate of completion. The job-placement specialist will create cooperatives with area temporary agencies. The veterans will start in this type of

position, gaining experience and getting comfortable in the business environment, with the prospect of its leading to full-time employment for many.

The job-training program will work to create additional entrepreneurial enterprises under DOL funding grants. Possible ideas include a cleaning company, a laundry company, an expansion of the security force to include outside contracts, and a temporary manpower service. Another venture comes from the Computer Factory, which is planning to develop an entrepreneurial business designed to employ and train veterans in data entry work. This program would in effect establish a data entry enterprise that would contract out work from companies in the Greater Boston area.

Since the shelter is a nonprofit institution, the program would be able to return most of the contract price to the veterans and thus undercut bids of competing companies. The only expenses of this program would be the costs of computer equipment needed to upgrade an old minicomputer and the salary of an administrator. It would accomplish two important objectives — training veterans in data entry skills and providing them with a source of income necessary to continuing the rehabilitative process. Along with temporary work opportunities, this program would give graduates of the computer training program an opportunity to gain important work experience. These additional programs will add to the variety of rehabilitation options in the job-training program.

The job-placement program provides counseling and placement services to the veterans of the shelter. The job-placement specialist assists veterans with such job-search tools as a résumé, an interview, and networking. The specialist also works to provide the skills needed to face today's job marketplace successfully. Utilizing the Veterans Unit at the Massachusetts Department of Employment and Training, he refers many veterans for additional counseling and job seminars to supplement the services that it provides at the shelter. For a number of reasons, many veterans have been away from the work force for quite some time. Understanding the veterans, the specialist recognizes that looking for a job is an emotionally trying process for many of them. Therefore, he takes a great deal of time to provide individual counseling to build veterans' self-confidence. The job-placement program also works at developing outside job opportunities with area businesses. The shelter is involved in a cooperative with a transportation company that delivers cars to various destinations. As of this writing, the company has employed more than twenty veterans. Establishing such successful cooperatives will continue to be the main priority of the job-placement program. The job-training and -placement programs work together to provide basic and innovative job services to give the veterans every opportunity to secure employment that allows them to continue the rehabilitation process.

The final step in this process brings the veterans to the Housing Department. Once veterans secure the means to remain self-sufficient, they are referred to the Housing Department. Here they are given assistance in finding suitable housing to satisfy their needs as to location and cost. Despite the lack of affordable housing in the Greater Boston area, the Housing Department works with such agencies as the area's housing authorities and the VA Housing Department to provide the veterans with affordable and acceptable housing options. The Housing Department has a variety of housing available. In addition to conventional apartments, there are also sober houses (rooming houses that ensure an alcohol- and drug-free environment), subsidized housing for the elderly (available to the veterans who are senior citizens), and single-room-occupancy units (SROs). In October 1990, the Department of Housing and Urban Development awarded the workshop a \$3.5 million subsidy to build

fifty-nine SRO units in its 17 Court Street facility. Delays in the acquisition of proper financing delayed the project for over a year. However, the workshop recently acquired the needed funds to initiate construction on these SRO units, which are to be occupied by veterans of the shelter, in early 1992. As a result, the Housing Department will have a new option to offer veterans. Housing is usually the final stage in the rehabilitation process, leading veterans out of the shelter into a place they can comfortably call their own.

A "Place" to Heal Veterans

The workshop has created a program specifically designed to address the needs of homeless veterans suffering from posttraumatic stress disorder (PTSD), the vast majority of whom are Vietnam veterans. Although this group is a relatively small proportion of the homeless veteran population, the workshop believes there must be a special commitment to them because of the poor treatment they received on their return from Vietnam. The emphasis on this program is to establish an environment conducive for the veterans to confront and then heal from their war experiences. To provide them with this opportunity, a combat support group meets weekly to address issues common to those who have experienced combat.

Last June the workshop sponsored a trip to Washington, D.C., for a group of homeless Vietnam veterans accompanied by counselors from the shelter. Its goal was to create an atmosphere conducive to healing old wounds. Through a carefully planned itinerary, which included touring the Capitol and the White House, laying a memorial wreath at the Tomb of the Unknown Soldier, and participating in individual and group counseling sessions, a camaraderie of spirit was achieved that prepared the group for the pain of going to the Vietnam War Memorial, the capstone of the trip. The visit to the Wall was a difficult but restorative experience for many of the veterans as issues that had been hidden for years surfaced. With the aid of counselors, they confronted their wartime experiences. For many, this weekend was the beginning of a long healing process, which they are still going through to reconcile themselves to their combat experiences. Coupled with follow-up counseling and referrals to the VA and its PTSD program, this trip aided many in getting their lives pointed in a positive direction.

The workshop is planning a companion outing to the Washington trip. It will be an outward-bound-style event, with a group of Vietnam veterans spending a period of time in the wilderness. It will attempt to create an environment similar to that of Vietnam — all camping equipment to be borrowed from the military — in order to draw out the veterans' repressed feelings about the war. With counselors guiding the veterans through the events, the trip would become another valuable tool with which to heal old wounds and to set them on the track to recovery.

The workshop is also planning to develop a history seminar concerning the United States' involvement in Southeast Asia for veterans who still possess only a vague understanding of their service in Vietnam. This class will be designed to answer Vietnam veterans' most common questions concerning the country's history. History departments of local colleges will be approached to participate by volunteering instructors or donating needed materials.

Along with the PTSD program, the workshop provides assistance to Vietnam veterans who were exposed to the defoliant Agent Orange. Through the Agent Orange

Class Assistance Program (AOCAP) specifically designed to assist the families of the veterans, the workshop provides a variety of the supportive services, including counseling to deal effectively with the effects of Agent Orange on the family and assistance in applying for disability claims. The majority of the program involves outreach in the homeless veteran community to identify those who were exposed to Agent Orange. After initial contact is made with a homeless veteran, the process of contacting the family is difficult and often lengthy because many homeless veterans are estranged from their families. With the development of the New England Consortium, which consists of service providers throughout New England who are directly involved in this issue, a strategy has been developed to effectively advertise the AOCAP program by informing families of its services. The objective of the workshop is to serve as many families as possible, trying to aid in healing the pain and trauma of the families' indirect exposure to Agent Orange.

In November 1991, the workshop invited the Vietnamese Veterans of Boston to tour the shelter, speak to the veterans at Monday night's Town Meeting, and serve them Thanksgiving dinner. Although this group was composed of veterans of the republic of Vietnam's military — troops commonly referred to as ARVN by American troops — it did not represent the enemy, but many Vietnam veterans had bad memories of the performance and loyalty of ARVN. The workshop felt that it would be good for both sides to meet and resolve some of the issues from the war. Many at the Town Meeting stated that "it was a time to heal." After a few concerns were addressed and the veterans sensed the sincerity of the Vietnamese in coming to the shelter, they welcomed them warmly and with the sense of brotherhood the veterans of the shelter have for one another. By serving Thanksgiving dinner to the veterans of the shelter, the Vietnamese veterans gave a little bit back to some of the men who fought to keep their country free. Through its various programs, the workshop is committed to addressing constructively the many issues of the Vietnam War in an attempt to heal the wounds of the Vietnam veterans so that they can take their rightful place in mainstream society. As the shelter's executive director frequently exclaims, "All they wanted to do was come home, and it's time they did."¹⁶

The Future

On November 11, 1991, the federal government awarded the workshop \$4.2 million, funds desperately needed to renovate the facility at 17 Court Street. This money will allow the workshop to repair the entire building, and expand its programs. The workshop plans to create such programs as its own detox unit and medical clinic to better serve homeless veterans. Despite the wide variety of services and programs created by the workshop to assist homeless veterans, one must not lose sight that the workshop is fighting a war on homelessness on the streets of Boston that it is losing. Since the shelter opened, nine of its former residents have died on the streets of Boston. Each Memorial Day the shelter holds a private in-house ceremony to honor them. In October 1991, Ken Norton, a Vietnam veteran, died of a massive heart attack on the floor of the shelter. His tragic death was news throughout the Boston area, but the death of his eight fellow veterans passed without an eyebrow being raised, without a tear being shed. One death of a homeless veteran on the streets of the country that he once defended is completely unacceptable, but nine of them is an outrage. The workshop is committed to ending the horrible tragedy of America's

homeless veterans. Waging the battle, the workshop has established a comprehensive program specifically designed to aid in the reintegration of all homeless veterans to their rightful place in the society they once helped to defend. ♪

Notes

1. Oliver Stone, *Platoon* (Los Angeles: Hemdale Film Corporation, 1986.)
2. *The 1990 Annual Report of the Interagency Council on the Homeless* (Washington, D.C.: U.S. Government Printing Office, 1990), 248.
3. Ibid.
4. Ibid., 39.
5. Joan Alker, *Heroes Today, Homeless Tomorrow?: Homelessness among Veterans in the United States* (Washington D.C.: National Coalition for the Homeless, 1991), 8.
6. "Sheltering Homeless Veterans," *Boston Globe*, March 23, 1990.
7. James Goodwin, "Readjustment Problems Among Vietnam Veterans," condensed from The Etiology of Combat-Related Post Traumatic Stress Disorder," in *Post Traumatic Stress Disorders: A Handbook for Clinicians*, edited by Dr. Thomas Williams (Cincinnati, Ohio: Disabled American Veterans pamphlet, 1989), 13-18.
8. Alker, *Heroes Today*, 21.
9. Jason DeParle, "Aid for Homeless Focuses on Veterans," *New York Times*, November 11, 1991, A-8.
10. Alker, *Heroes Today*, 1.
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The Manufacture of Dependency

Shelterization Revisited

Kostas Gounis, M. Phil.

Emergency shelters have been the most comprehensive and enduring response to homelessness in the United States, with New York City leading the way since the early 1980s. Shelters have emerged as a hybrid between a degraded type of "public housing" and a new form of "institutionalization." The persistence of shelter dependency, or "shelterization," is an intractable problem that frustrates policymakers and service providers. Popular among certain circles of professional pathologists is the view that shelterization is a form of "adaptation" to the violent, anomic, and generally antisocial environment of the shelter. This explanation of shelter dependency is theoretically flawed and intentionally leads to suspect practices because it inverts the causal connection between structural arrangements and individual behavior. Following Goffman, this article exposes the institutional origin of the pathologies that are usually attributed to homeless people as self-inflicted. The obstacles that prevent homeless people from rejoining the mainstream are the effects of a state of captivity, not the symptoms of a disease.

"Emergency" Shelters for the Homeless

In various cities across the United States, the most comprehensive and enduring response to the rise of homelessness has been the system of shelters.¹ As an instance of massive displacement of human populations, homelessness is the contemporary domestic equivalent to the plight of exiles and refugees uprooted from their communities by natural or, more frequently, human-made disasters. In turn, shelters for homeless persons replicate the degrading conditions that define the functions of institutions designed to segregate and warehouse populations that are rendered marginal and may be perceived to embody intentional or unintentional dangers to dominant society.²

Shelters began as a temporary measure with the manifest function of providing the basic material needs that could not be met in the absence of a home. Shelters perform the material functions of "home," but without the representations and social practices that we normally associate with the idea of "home." At the same

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time, shelters look like refugee camps or institutions of incarceration like prisons and concentration camps. Furthermore, the conditions in many shelters replicate the notorious "back wards" of mental asylums of the past, primarily functioning as custodial institutions where mentally or physically disabled residents are abandoned to the ruthlessness of shelter life, provided, if at all, with minimal specialized services, and are generally victimized by shelter staff and other residents.

Since the early 1980s, the shelter system of New York City has expanded far beyond the confines of traditional skid row areas, that is, the Bowery, which until the late seventies seemed to contain the majority of the visibly homeless and otherwise marginal individuals. During the past decade, shelters of a variety of types and sizes developed into an elaborate institutional apparatus. There are municipal shelters for men, for women, and for families. In addition, a policy of "segmentation" has been enforced since the late 1980s, whereby individual shelters are designated as "specializing" for particular types of clients — for example, mentally disabled, elderly, drug abusers, "employable," and so on. Alongside the municipal system, a network of "private" shelters, usually small in size, has been operated by a variety of nonprofit, mostly religious, organizations. A 1989 survey by the New York Planning Department counted a total of 326 shelters with a capacity of almost 30,000 beds.³

By the mid-1980s, the shelter system radiated out into armories, old schools, abandoned hospital wards, and other facilities throughout the city. Most shelters were located in neighborhoods in advanced stages of urban decay where community opposition to the presence of these facilities was minimal or ineffective. By the late 1980s, the municipal shelter system for single men — the ethnographic context for this discussion — included more than fifteen individual sites and on an average night accommodated more than 8,000 men. Shelters became an emergent form of "public housing," and the traditional denizens of New York City's skid row — primarily older, white, and alcoholic — had become a minority in the New York City shelter system. By 1985, most of the users of the men's shelter system (74%) were under forty years old. Seventy-one percent were "black" and 19 percent "Hispanic."⁴

The public debate surrounding the irreversible growth of the New York City shelter system and its intended and unintended uses by both "providers" and "clients" testifies to the complexity of the problem of homelessness: some have claimed that the function of the shelters is to serve as surrogate asylums for the mentally ill or as new back wards — for a while, reinstitutionalization became a fashionable term; advocates have fought a long campaign, with uneven results, to locate the causes of homelessness in the harsh economic realities of the Reagan era and the housing policies promoted by the New York City administration since the late 1970s;⁵ mental health professionals have debated the extent to which mental health policies have contributed to a social problem of such magnitude.⁶

During the early phases of the development of the New York City shelter system, individual shelters operated in an ad hoc fashion. Primary among the factors that contributed to the lack of organizational uniformity were the "emergency" designation and makeshift organizational character of most shelters; the degree of reliance on inmate involvement in operating the shelter in view of the chronic shortages in staff and resources; and staff-inmate cooperation in the "underlife" of these institutions, especially in the underground shelter economy of drugs and other exchanges of licit and illicit goods and services. Over the past decade, however, there has been considerable evolution in the organization and functions of the "flourishing shelter industry."⁷

Through the promulgation and more stringent enforcement of regulations primarily aimed at controlling the inmate population, shelters have become increasingly regimented and have emerged as an enduring institutional arrangement. The paramount operational concerns in a public shelter are social control and the minimization of disruptions and the ever-present potential for violence that is endemic in custodial institutions, especially in those where an already impoverished and marginalized population is forced to compete for the dubious benefit of access to generally degrading services and material resources.

Another element that has contributed, sometimes paradoxically and contrary to original intentions, to the institutional maturation of New York City shelters has been the introduction of additional services, usually in the form of on-site clinical programs. The long debate on the connection between mental health policy and homelessness — the role of deinstitutionalization, the prevalence of mental illness among shelter inmates and other homeless groups, the need for on-site clinical interventions, the range of obstacles encountered by such initiatives, to name only a few of the themes — has produced, along with a fair amount of controversy, a definite mental health agenda for these populations.⁸ Both inside shelters and in the streets, a variety of clinical programs have been designed. The stated objectives of such programs have been to identify, engage in some kind of treatment, and eventually relocate mentally disabled homeless persons. However, the risk and the paradox is that, instead of fulfilling their objectives in assisting shelter users to find appropriate housing in the “community” and connecting them to adequate clinical and social services, shelter-based programs tend to become part of the shelter and an elaboration and expansion of the shelter’s technologies of control.

The overall effect of the enhanced capacities for discipline and control, coupled with the expansion of the range of interventions into the lives of residents through the introduction of additional services, lend these institutions a more “total” character, even when the latter are intended for improving the lives of shelter residents. In these circumstances, then, shelters residents may properly be called shelter “inmates.”

Shelters lend themselves to multiple uses. Entrance is theoretically voluntary, although the authorities have made it increasingly difficult for homeless persons to occupy public spaces such as parks, subways, or transportation terminals, thus forcing them to enter the shelter system. Also, there are no formal restrictions on movement between the shelter and the community. Many residents are employed in legitimate or illegitimate work on the outside and use the shelter only as a place to sleep and shower. Collecting returnable cans and bottles, wiping windshields, dealing drugs, defrauding Medicaid, prostitution, or temporary jobs are examples of the “makeshift economies” of the urban poor in which shelter residents participate.

Others visit with family or friends, often trying to repair social ties and be allowed back into the household. Many attend programs such as school, job training, mental health, or detoxification — indeed, there is a whole industry that endlessly prepares people to “reenter society.” The scarcity of alternative housing arrangements, coupled with policies that bar homeless persons with histories of psychiatric disabilities or drug abuse from existing housing, make shelters the only available recourse for a significant portion of the homeless population. Also, many mentally disabled individuals prefer shelters over the more regimented, segregating, and stigmatizing option of mental hospitals and other mental health facilities. Thus, in spite of increased regi-

mentation, shelters remain relatively open institutions, a hybrid between a degraded type of public housing and a new form of institutionalization.

Constraints

With few and far between exceptions, past efforts to design programs that would help people escape shelter dependency form a long string of failures and frustration. The success or failure of such efforts depends on contingencies stemming from two separate sets of constraints: first, those imposed by shelter life; second, those set by the "outside" world. This article focuses on the former set, the world of the shelter. The latter set, the political economy of homelessness, is beyond the scope of this essay. However, the intentional and systematic dismantling of the "safety net" that sustained a significant segment of the dependent poor in the community and the paucity of opportunities and absence of resources in today's socioeconomic environment constitute the ever-present context and define the boundary conditions for this discussion. The withdrawal and denial of "community" experienced by homeless persons in general is the overwhelming fact that accounts for both the development of the shelter system and the perpetuation of shelter dependency.¹⁰

With or without a proper understanding of the role of wider socioeconomic conditions, there is abundant evidence to suggest that efforts to quit shelter life, whether initiated by shelter inmates themselves or through programmatic interventions, encounter significant obstacles *inside* the shelter. Clinicians report immense difficulties in engaging the attention of their targeted populations in pursuing alternatives to shelter living; the social milieu of the shelter is reported to sabotage treatment efforts; social skills conducive to community living are seen as grossly compromised or entirely lacking; social workers often talk of the need to *resocialize* these people; and significant divergence between the objectives of service providers and client uses of program resources has been repeatedly observed.¹¹

Shelterization

My ethnographic research and the clinical experience of many professionals with whom I have worked with over the past eight years suggest that the successful engagement into treatment and the possibilities for relocation are seriously undermined by adjustments in behavior and self-perception that mediate the acceptance of shelter dependency.

The process that brings about these adjustments has been described as "shelterization." The term was first adapted to current usage during the design of a specific intervention at a New York City shelter for men.¹² The use of this term was intended to focus research and clinical efforts on the specific type of institutionalization that is brought about by the shelter environment.

Shelterization describes the complete immersion of a shelter resident into the routines of shelter life. It involves the gradual acceptance of the institutional views about oneself and the institutional appropriation of one's short- and long-term objectives. Shelterization becomes manifest through a range of adjustments that include subscribing to the "homeless" identity; striving to secure marginal benefits in the shelter's impoverished and highly competitive social economy; focusing more attention

and effort on immediate, tangible gains, and less on distant plans for escaping shelter dependency; reinterpreting the uses of all available resources, regardless of their intended function, according to current, shelter-based needs.

I have repeatedly observed and confirmed with a variety of professionals the fact that manifest mental health needs were *not* the primary concern that drove many shelter residents to seek services at a number of on-site clinical programs where ethnographic research and service provision have been undertaken. Instead, affiliation with an on-site mental health program has been valued more as a source of securing benefits and services entirely different from the clinicians' original agenda: sanctuary from the chaotic and violent world of the rest of the shelter — a shelter within a shelter; alliances with professional and respected individuals who can intercede on one's behalf in the event of clashes with staff; material benefits such as coffee, food, and cigarettes; access to a telephone; and an overall improvement of one's conditions of existence inside the shelter. The possibility of alternative uses has, in fact, been the reason that a significant segment of clients at these programs has neither needed nor utilized the clinical services offered.

Perhaps the most important dimension of shelterization is the institutional appropriation of one's *time*. The temporal structure of shelter organization dominates the inmates' daily life.¹³ The large scale — up to one thousand men, in some cases — and the custodial functions of shelters make time an indispensable regulatory and organizational principle. Curfews, standardized schedules, and waiting in lines — for food, to sign up for one's bed, for toilet paper, to see a social worker — are examples of the daily shelter routine. Keeping up with this routine requires considerable investment of time and effort.

Scarcity and the frequently punitive nature of the way shelter services are dispensed make daily subsistence a full-time occupation. Activities such as eating, sleeping, or taking a shower, which, for those with homes are normally classified as leisure, become the work of homeless people, in general. For those in shelters, this inversion in the meaning of work is institutionally enforced, primarily through the use of temporal instruments of control. By transforming the most basic activities of personal sustenance and reproduction into an all-consuming activity, the temporal organization of shelter life functions as the centripetal force that produces shelterization.

Inversions

Shelterization has already been a contested category. Besides questions concerning its history,¹⁴ the relative popularization of the term as an explanation for the persistence of shelter dependency has been intellectually misguided and clinically irresponsible. Both in the mass media and in professional circles, a variety of professional social pathologists has presented shelterization as a "syndrome" that explains why people remain entrapped in the shelter. The following is an excerpt from an article in the *New York Times*.

By adapting to the dangers of shelter living, homeless people make the journey back to a normal life even harder . . . life [in the shelter] revolves around trying not to be a victim of crime that is rampant and virtually unpunished, particularly homosexual rape, assault and theft . . . [Shelter residents] may adopt bizarre behavior, like flailing one's arms from time to time, or may cultivate uncleanness."¹⁵

In fact, the *New York Times* was popularizing an article published in the professional journal *Hospital and Community Psychiatry*, which belabors these points in somewhat more rarefied language.

[Shelter residents] learn the importance of strange behavior for deterrence purposes . . . Despite dangerousness and depersonalization, residents do not flee the shelter. Instead, they stay and develop coping strategies that provide them with a feeling of mastery unparalleled on the outside.¹⁶

Such sensationalist and preposterous caricatures of shelter life are offered as examples of adaptive strategies that define and explain shelterization. According to this formulation, shelterization is seen as a process that reproduces shelter dependency through the gradual adoption of shelter rules of behavior and by focusing inmate attention and priorities away from participation in normal life and into the cultivation of survival skills uniquely suited for the predatory, unsafe, and generally pathological social environment of the shelter. Thus, shelterization is offered as an adaptation to the danger, apathy and social withdrawal, dependency, and general anomie that shelter residents indulge in. In other words, they are adapting to . . . themselves.

The apparently true proposition that shelterization is an “adaptation” to the specific social ecology of the shelter is seriously flawed. It is bogus theory that guides questionable and harmful practices. If the various behaviors (traits) that comprise shelterization are viewed as adaptations to an environment that is shaped by these same behaviors, the argument becomes a tautology — not an uncommon error in the use of the concept of adaptation when applied to social processes. Social processes, however, do not lend themselves to the same analysis through the paradigm of adaptation as biological models do. (The environment that produces shelter dependency is not a neutral collection of ecological conditions where certain traits are randomly “selected for.”)

But more than logical consistency is at stake. This version of shelterization ignores the institutional structure and presents the residents as both perpetrators and victims. The proposition that shelterization can be a useful conceptual category in understanding the range of pathologies to be encountered in the shelter depends on a proper assessment of *agency*: if shelterization is to be viewed as an adaptive strategy, the factors that shape the social ecology one is adapting to must be examined. That is, we have to ask, Who is doing what to whom?

Shelterization needs to be analyzed by heeding Goffman’s methodological admonition “to understand the social problems and issues in total institutions by appealing to the underlying structural design common to them all,” which concludes his best-known essay in *Asylums*.¹⁷ Instead, the emphasis has been on interpreting shelter malaise as a self-inflicted condition. The causal hierarchy is usually inverted and the responsibility in engendering these phenomena is shifted from the institution to the inmates. Also, Goffman’s important distinction between “primary” and “secondary adjustments” is also ignored.¹⁸

Primary adjustments are the direct result of the institutional appropriation of the inmate’s time, interests, and perceptions about himself. They are the effects of the “encompassing” tendencies of total institutions. Secondary adjustments, on the other hand, are the domain of the “underlife” of the shelter. They are the “ways of making out” in a degrading institutional setting that, for all intents and purposes, add insult to injury: homelessness as an experience of dislocation and exclusion is

compounded with the direct assault upon the self by the mortifications of institutional life. To give priority to the negative traits that are the symptoms of shelterization is to invert, again, the causal relation between these two types of adjustment.

Unlike the analysis of institutionalization that identifies the logic of the institution as the primary agency effecting the phenomenon of immersion into the roles and identity of the inmate, the popular view of shelterization focuses on the secondary adjustments in the inmate world and ignores the structural dimension altogether.

Neither is shelterization an adaptation to the so-called disaffiliation of the homeless, that is, the alleged loss of normative social values. Disaffiliation may have been an appropriate term in describing the traditional skid row denizens.¹⁹ Homelessness, however, is a condition that affects entire communities, not isolated individuals. It is a social problem, not "personal troubles," as C. Wright Mills would say.²⁰

The pathologies that are observed inside the shelter — crime, drug and alcohol abuse, untreated mental disabilities, AIDS — are simply an extension and an intensified form of the collective misfortunes of the marginalized populations that comprise the so-called underclass. The ways in which the activities of shelter residents depart from mainstream values and practices are a reflection of the social exclusion and economic redundancy of these communities, rather than symptoms of pathology. The functions of shelters are determined by the "survival economics"²¹ of households in communities subjected to the combined assault of the economic forces of the market and the social neglect of the state. For the most part, shelters serve as collective "community bedrooms" by partially removing the burden of caring for individuals whose behavior and needs present an extraordinary strain on the viability of these embattled households.

My ethnographic experience in several New York City shelters indicates that the residents' loss of community ties is primarily a function of the way shelters operate, rather than evidence of disaffiliation. Frequently, homeless individuals are dispatched to shelters located far from the neighborhoods these men and women come from. Distance and cost of travel contribute to the isolation of residents from networks of relatives and friends on the outside. The end result is prolonged stays inside the shelter and a gradual withdrawal and demoralization.

On the other hand, shelters located amid the poverty-stricken sections of the city tend to recruit their residents from the nearby communities. The majority of residents at these sites are constantly moving between the shelter and the outside, especially during the initial phases of shelter dependency. They do so in pursuit of alternative living arrangements, in search of jobs, and in an effort to maintain or repair ties with families and friends. (This dynamic may be reversed if city authorities enforce more rigorously the policy of "segmentation," by which homeless individuals will be assessed for the type of services they need and directed to shelters designed to provide these services.) The effort to resist shelterization is most evident among new arrivals who distance themselves from the shelter, both physically and psychologically, and proclaim their determination to "not become like the rest of these guys," whom they see entrapped by the routines of shelter life.²²

Violence and Abuse

New York City shelters are notorious for violence and generally unsafe conditions. Invariably, the violence is attributed to the deviant social nature and psychological

makeup of the population that utilizes city shelters. Frequently, individuals who work in these facilities, from front-line, custodial staff to certified professionals, are eager to relate war stories from the shelter front. Such tales, aimed at impressing captive audiences with the narrator's intimacy with the underworld of homelessness, rarely point a finger at the institutional sources of this anomie or at the regular instances when staff actually perpetrate the violence that is endemic to the shelters.

The organization of shelter routines — waiting in lines with another few hundred men in order to get to eat a miserable meal; being constantly subjected to the mortifications of institutional living; being constantly exposed to the degradations, violence, and arbitrariness visited on inmates by staff — propagates violence and an intense competition, by whatever means necessary, for access to scarce resources. By seeking to account for violence as an intrinsic characteristic of the inmates, the institutional origins of this violence are obscured and the disciplinary and punitive mentality that informs the practices of shelter authorities is presented as an inevitability stemming from the nature of the population itself. The shelter manufactures violence, hopelessness, and all the symptoms of social pathology that the authorities attribute to the very victims of these processes as self-inflicted. Research that fails to account for the structural and organizational factors which engender violence, demoralization, and hopelessness among shelter inmates plainly abuses its privileges by absolving the shelter system of any responsibility for the abuse of its victims.

From a structural perspective, shelterization is not an adaptation to violence, theft, drug dealing and use, "homosexual rape," and the rest of the evils of shelter life. Nor is it coterminous with the behaviors that allegedly prevent inmates from rejoining the mainstream. Shelterization is a state of captivity, not a disease. ■

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22. Gounis and Susser, "Shelterization."

A Single Man and Christmas

Steve Johnson

He has no one to be
near, so there is fear
he is not really alive
at all.

He feels the downfall
of his single life
like the fall of snow
that his lonely steps
tread.

He knows there is
only time, and that
Christmas is no different.
The hour still has its
minute minutes in its
being, a person with
time to decide his
determined necessities
and limits — of existence
from his consciousness of person.

So he follows his
style and desire in
his reason of reflected
imagination.

He allows his hands
room in his pockets
and walks the town
in winter air, dressed
in his hand picked
selection to the way
he wished to look.

His steps are
uncertain, but their
repetition passes the
time.

So he walks long
distances, through day
and night, to exist
with the natural forms
and forces of winter
nature.

Hoping to find
peace in the day's
air that he listens
to, like another
person listens to
another person, air which
is the person of
himself. He walks and
walks, thinking of human
affection and adventure.

Knowing his bed
will at least be there
to fall into, because
his many lonely steps
have tired his single
form.

12/28/89

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Homelessness in Boston

The Media Wake Up

Ian Menzies

Why did it take the media so long to “discover” and report on the dramatically rising rates of hunger and homelessness throughout the nation? Did that failure make it easier for presidential counselor Edwin Meese to declare in December 1983 that allegations of hunger in America were “purely political” and that people who go to soup kitchens do so because the food is free, statements matched a short time later by President Ronald Reagan’s claim that people who sleep on grates do so “by choice.” In this article, Menzies tells the unfolding story of how hunger and homelessness finally became a recognized issue in one city — Boston — how he became involved, how the story developed, and why he believes the media took so long to react.

It began for me, not inappropriately, in Boston’s historic Faneuil Hall, a building that for 250 years has resounded frequently to challenging calls for action.

The occasion was an all-day meeting to discuss “The Role of the Church in the City,” a hearing sponsored by the Episcopal Diocese of Massachusetts. Along with others, I had been invited as a panelist “to listen to testimony and ask pertinent questions.”

The date was October 31, 1978.

Those testifying included a broad spectrum of people concerned with the inner city, among them Governor Michael Dukakis, Superintendent of Boston Schools Robert Wood; Larry Myer of Project Bread; Jack Calhoun, commissioner of Youth Services; Father Thomas Corrigan of Fair Share; Alex Rodriguez of the Massachusetts Commission Against Discrimination; Ron Hafer of Urban Edge; and some fifteen clergymen and sisters of different faiths.

One testifier in particular made me sit up and take especial notice; that was Kip Tiernan, founder in 1974 of Rosie’s Place, a shelter for homeless and abused women in the South End. Tiernan, who to me will always be “the nun in the soft hat,” is an articulate, passionate woman who knows the value of shock treatment and uses it to her considerable advantage.

Ian Menzies, a former managing editor, associate editor, and columnist of the Boston Globe, is a senior fellow at the John W. McCormack Institute of Public Affairs, University of Massachusetts at Boston.

Her introductory remarks before the Episcopal bishops and other clergy on that last day of October fourteen years ago, which I filed for later reference, are worth repeating, and I leave it up to the reader to judge their shock value.¹

"Sisters, brothers," she began, "here we are again at still another commission, at another public spectacular of the walking wounded. It is nice of you to come to us. You've probably noted that lots of us don't come to you anymore. Roman Catholics had something like this recently, and it was called the 'Call to Action.' So far all we get out of that, from my own jaundiced view, is more workshops, more seminars, and communion in the hand. I hope the Episcopal hearings offer substantially more."

Tiernan, a key player in the poor people's network, then pointed out that it was because of the growing number of homeless in the city that she and others had founded Rosie's Place, adding that gentrification — the buying and renovation of handsome old Victorian row houses in the South End — was a contributory factor to homelessness, having taken six hundred rooming houses off the market.

Near the end of her testimony, Tiernan asked, in rising tones, what the church had done for Rosie's Place, for the mentally ill, or for those left homeless by the meat-ax 1975 welfare cuts. "The church," she said, "unless it develops a political theology to go along with the times, is of no value to us. What would Jesus do? Do you think He'd form a committee? Why is it so hard to live the gospels? Jesus was a passionate man. He took sides with life."

When she finished there was silence. Then Episcopal Bishop Brooke Mosely of Philadelphia said, quietly and thoughtfully, "That was a prophetic statement from the very heart of our Christian theology."

That tableau remains vividly with me to this day. It was like a morality play. It *was* a morality play.

On November 6, 1978, the heading on my column in the *Boston Globe* read: "Are Churches Failing the City and Its Residents?" It created quite a stir, which went deeper than the several critical and defensive letters to the editor that followed.²

Most media people knew about the Pine Street Inn and its good works, but we thought about it as catering to a small number of down-and-outs who, as they used to say, "are always with us." What Kip Tiernan was trying to tell us was that things were worse than we thought. But we, myself included, didn't quite get the message, not yet.

Although I followed up with other columns on the churches, I got sidetracked, because at the time the emphasis among Greater Boston's churches was toward world peace and local racial understanding, as, for instance, when the church-led Covenant for Justice, Equity, and Harmony was formed in November 1979 following the shooting in Charlestown of a fifteen-year-old black schoolboy named Darryl Williams.³ The mood of the time was focused on racial harmony almost, in retrospect, to the exclusion of hunger and homelessness as a priority. Even a twice-a-week column somewhat limits the range of topics one can cover; nevertheless, I should have followed up on Kip Tiernan's remarks. But what was inexcusable was that the newsroom did not, especially as it was suggested they should.

It was interesting to recall that 275,000 signed the covenant pledging support for racial understanding, and to the surprise of some, the usually quiet, reserved Humberto Cardinal Medeiros spoke out passionately, saying, "Racism, root, stem, and branch must now and forever be driven out of the hearts and minds, out of the

living rooms and neighborhoods, and out of the social atmosphere and institutions that make up Boston.” He did not mention hunger or homelessness. This was the same year, 1979, that Pope John Paul II visited the city.

Tiernan, however, had gotten through to my subconscious, because shortly after her Faneuil Hall testimony, I reacted angrily to a December 1978 story in *Harper's Magazine* headlined “The Urban Crisis Leaves Town,” and then, in much smaller print below, “and moves to suburbs.”

How, I asked in another *Globe* column, can the media claim that the urban crisis has left the cities when the facts say just the opposite? “What is frightening,” I wrote,

is that *Harper's*-type stories have enormous influence, especially on those who are against cities, which seems to include much of Congress.

The frenetic search by writers who covet notoriety is no longer merely a fad designed to entertain but a full-blown social menace that can affect the destinies of millions.

Writers are so absorbed in self-promotion, in personal aggrandizement, in bottom-line competitiveness, that they truly know not what they do, nor whom they hurt.⁴

One has to wonder just how much stories like *Harper's* — and there were others — led the Reagan administration to deny, even five years later, that hunger existed, but we'll come to that.

Hunger and homelessness were simply not issues in the media during 1980 and 1981, at least not directly, although I noted in a column in December 1980, following an interview with Lewis (Harry) Spence, that homelessness was on the rise.⁵ In February 1980, Judge Paul G. Garrity had appointed Spence to be the receiver-administrator of the Boston Housing Authority — the same Harry Spence who is today trying to resuscitate the city of Chelsea with receiver James Carlin.

The gist of the column was the positive progress Spence had made over ten months in improving housing conditions for many of the fifty thousand tenants (one in ten of the population) who, at the time, were living in public housing in Boston. I closed the column with a quote from Spence that “the day is coming when some people in Boston just won't have any shelter, they'll be on the street. Boston is touted as a livable city, which it is, but it could dramatically come apart.”

Let me now fast-forward to September 1982 and an invitation from the United Community Planning Corporation (UCPC), the planning arm of the United Fund, to speak on “pressing community issues.”⁶ Recalling the Faneuil Hall tableau three years earlier, I thought, Who better to call than Kip Tiernan of Rosie's Place? — which I did — and I called others as well. My little speech included a plea for the United Fund to endorse the need for national health care, and I pointed out that many of those they served received the least care.

Then, explaining that I had done some street research as well as talking to those aiding the poor, I moved to more local concerns. “People in Boston are going hungry,” I said, “and we are not meeting those needs. The housing situation is also alarming. The task of meeting critical urban needs is being left almost solely to volunteer groups who work with the poor and underprivileged. Wouldn't it perhaps be possible to make available some free-floating United Way funds that could be dis-

tributed directly to those alternative groups such as the Boston Food Bank and Project Bread?" I had stuck my neck out a bit and hit an embarrassing weakness in the United Way at the time — a rigidity in allocating funding, a lack of flexibility.

On October 7, 1982, I led off my twice-weekly column on the front of the Metropolitan page as I had my talk: "There Is Hunger in the City of Boston . . . but just as critical as the food shortage is the lack of shelter, the growing number of homeless." I quoted the Reverend Tom Kennedy of Trinity Church, which had run a "ministry for transients" for forty years, as stating bluntly, "We, the churches, have failed to get together and collectively pressure government to build low-cost housing, but we must." I concluded: "Until public agencies get their act together, the United Way could perhaps, through a more flexible approach, help fill the hunger gap. The public has been poorly informed. If asked to help, the public would respond."

Clearly, and this is a point that needs to be made, the media bore as much, if not more, responsibility for the public's being ill informed on hunger and homelessness, particularly the latter, as did the United Way, charitable institutions, and state and local welfare agencies. To their great credit, the UCPC called a meeting for November 2, 1982, entitled "Hunger in Greater Boston," to which shelter and food-bank people were invited, as were representatives of banks, corporations, and foundations.

Having been invited to attend the meeting by UCPC president Nancy Beecher and executive vice president Jerome Wild, I did a follow-up column on November 4, summarizing the discussion.⁷ Some snapshot remarks included:

Dan Daley, then head of Project Bread: "Most of us are totally sheltered from the sights of people who are really hungry."

Nancy Beecher: "Aren't there any contact points between government and those going hungry?"

Paul McGerigle of UCPC: "There is no legal responsibility in the Legislature for food and homelessness. Hunger is no one's responsibility in Massachusetts."

Eileen Brigandi of Rosie's Place: "If you're homeless you can't get welfare. You must have an address. It's Catch 22."

Carol Johnson, Massachusetts Coalition for the Homeless: "Why hasn't the city raised the question of hunger and homelessness? Why is it doing nothing?"

Dan Daley: "We worry about those we don't see — the proud poor who won't take anything they don't consider rightfully theirs and mothers supporting children on minimum 'fast food' wages and the locked-in elderly."

It was a quiet and powerful story that had a strong impact on UCPC officials who, as planners for the United Way, recommend where collected moneys should go. There were also helpful clarifications made at the meeting as, for instance, when Larry Meyer, then head of the Boston Food Bank supplying some 425 pantries and on-site emergency food centers in Greater Boston, said that it wasn't so much more food that was needed but trucks, freezer space, and staff to distribute it. That meeting resulted in the establishment of a \$300,000 fund by the United Way to respond to emergency needs, and the establishment of an entirely new strategy.

In a November 25, 1988, column,⁸ I was able to write that the response to my "There Is Hunger in Boston" column resulted in contributions of close to \$5,000 from readers, according to Dan Daley. People also called to volunteer their services. Three weeks later, on December 16, 1982,⁹ I was able to report that the late Gino

Bellotti, then executive director of the Permanent Charity Fund of Boston (now the Boston Foundation), with an endowment of close to \$100 million and an annual distribution of \$8 million, had made a \$50,000 grant to set up a Project Bread Hunger Hotline, to be run by JoAnn Eccher, a nutritionist. Nevertheless, outside of the Greater Boston Walk for Hunger, also sponsored by Project Bread, there was still minimal attention being given to hunger or homelessness in Massachusetts by the state, the city, or the media.

I concluded my November 25 column by saying that “without the men and women who give so much of themselves to help the homeless and hungry, there would be nothing. Government, at all levels, has walked away from this responsibility. It is something the public should know.”

In early February 1983, Dan Daley called to tell me that *Globe* readers had contributed \$30,000 to Project Bread since the succession of columns began, a gesture he described as “absolutely incredible,” and one that surprised me as well, as I was not in the fund-raising business. Along with \$20,000 from the United Way and \$50,000 from the Permanent Charity Fund, the people of Greater Boston and its voluntary agencies had put together \$100,000 to meet the emergency.¹⁰

A month earlier, Governor Dukakis had gotten into the act, pledging state aid to all those in “desperate need” — a commitment passed along to his then director of the new Office of Human Resources, Philip Johnston, but the promise was never fulfilled. Members of the dedicated homeless-hungry network were caught by surprise by the governor’s call for a statewide effort to aid those to whom they had been ministering, but they accepted it with “cautious enthusiasm,” as I outlined it in a column on January 13, 1983.¹¹

Another facet of this whole story I found myself covering began in the fall of 1982, when the Boston Food Bank and Project Bread asked Dr. J. Larry Brown of the Harvard School of Public Health to evaluate the rising need for emergency food in Massachusetts and to survey 172 Greater Boston food pantries and 35 soup kitchens. Dr. Brown, director of the school’s Community Health Improvement Program, agreed to the request just as some Boston physicians began to report an increase in hunger-related health problems among their patients, particularly children and pregnant women.

In April 1983, Dr. Brown, testifying before the U.S. Senate’s Agricultural Subcommittee on Nutrition, chaired by Robert Dole, said the effect of the federal Omnibus Budget and Reconciliation Act of 1982 had resulted in 40 percent of the commonwealth’s schoolchildren being dropped from the school breakfast and lunch programs, nearly 20 percent of families being deprived of food stamps, and more than 20 percent of children being dropped from Aid to Dependent Children.¹²

“Altogether,” he testified, “364,000 people in Massachusetts, mainly children, lost the ability to participate in nutritional programs and these are not the most impoverished Americans — the so-called ‘old poor’; but the ‘new poor’; people who have been living on the margin and who then lost the support of these programs.” I wouldn’t say Dr. Brown’s testimony died aborning, but it certainly didn’t trigger any headlines or investigative media follow-ups throughout the nation.

Rumors that there was a “hunger situation” did eventually reach the White House, and in the summer of 1983, President Reagan announced that he would set up a task force to look into “reports of hunger,” which he did, but the task force was loaded with people who were on record as disliking what could be termed “hand-

out” programs. But before the report was even made public, Edwin Meese, counselor to Ronald Reagan, came out with the gauche remark that hunger in America is “purely political” and “that people who go to soup kitchens do so because the food is free,”¹³ — churlish, inaccurate remarks almost topped by his boss’s own ill-informed generality that people who sleep on grates do so “by choice.”¹⁴

These sound bites, of course, made page 1 without difficulty, whereas the growing tragedy of hunger and homelessness that led to the insensitive, ignorant remarks by Reagan and Meese did not. Interestingly, it was the day after President Reagan announced the “no-holds-barred” task force on hunger that Dr. Brown reported, following a study, that hunger was affecting 20,000 individuals in Massachusetts and that soup kitchens in the commonwealth were serving 200,000 meals a month.¹⁵

For about a year, in the course of going about my business in the downtown, I would see a long line of people, men and women, queued up outside Saint Anthony’s Shrine on Arch Street, waiting for a lunchtime sandwich prepared by the brothers. It was sad, disturbing. I had also heard that the rector, Father Louis J. Canino, OFM, who wanted to do more for the hungry and homeless than just serve cold sandwiches, had been shopping around for a building that he could convert to uses better able to serve the needy.

By now I was very much into the whole subject of hunger and homelessness throughout the state and obviously, through my columns, had become somewhat of a missionary (a columnist’s prerogative), prompted in part by what I felt was the *Boston Globe*’s weak coverage of both hunger and homelessness and the poor and underprivileged, which had not been the case back in the 1960s. Its indifferent coverage was, however, no worse than that of the rest of the media.

After an energizing interview with Father Canino, I opened my December 15, 1983, column as follows:

Edwin Meese may question if there is hunger in America. The Franciscan Friars of Boston do not; they know there is.

What’s more they have taken a dramatic step-up to expand their service to the city’s homeless and hungry.

Led by Rev. Louis J. Canino, rector of St. Anthony’s Shrine, the Franciscans have purchased an 11-story building in downtown Boston to aid their ministry to the poor.

It will not only serve as a sit-down soup kitchen for both street and poor people, but will also provide clothing, showers, nursing care, professional guidance and, says Fr. Canino, “give back to some the dignity they have apparently lost.”¹⁶

Then we came to the bottom line, the question of the \$125,000 down payment for the handsome eleven-story building at 39 Boylston Street, between Washington and Tremont streets — negotiated without public announcement. Father Canino had posted a Letter of Appeal at the entrance to the Arch Street Shrine, where two to three thousand attended Mass daily. It was the first time the Franciscans had made a public appeal for money in their more than thirty-year tenure at Arch Street.

Nevertheless, people responded. The building fund mounted, but could Father Canino raise the \$125,000 by the deadline of October 16? On October 14, he was still short \$40,000.

At that point he called a man who had said he would leave some money for an improved soup kitchen when he died. “I told him,” said Father Canino, with a

chuckle in his voice, "that I couldn't wait until he died, that we needed the money in two days, and I suggested that he sleep on it because I didn't want to pressure him. He came in with a check for \$10,000 the next day, and other checks followed." Again *Globe* readers responded, contributing thousands of dollars.

Father Canino passed papers December 1, 1983, and with a heavenly glance upward, said he planned to open Saint Francis House on January 30, 1984, although to do so he would still have to raise another \$200,000 for renovations and mortgage payments by that date. Few thought he could do it, but although the opening was delayed nine months because of the need for an entirely new heating system, the smiling friar, now a member of a Franciscan team in Greensboro, North Carolina, made it — thanks, he said, to great help from Kitty Dukakis, wife of the governor, corporate executives, *Globe* readers, and friends.¹⁷

One of his great hopes, currently being fulfilled, was to help guests of Saint Francis House find jobs. "A person can't even apply for a job," he said at the time, "unless he or she looks clean and neat. That's where we can help. We'll also be providing an address." A local bishop characterized the Father Canino story accurately, describing it as "nothing less than a leap of faith."

Saint Francis House is today the largest day shelter for the homeless in New England, providing meals, clothing, health care, crisis intervention, job counseling, and substance-abuse and psychiatric counseling as well as pastoral counseling. Although the Franciscans have all the responsibility for the building, staff costs are picked up by the city and the state because, as one observer commented, "Regular bureaucratic agencies could never act with the same sensitivity as this humanitarian group."

What I learned from this wonderful and rewarding experience is that the media — newspapers, television, and radio — are doing a disgracefully poor job of "covering" the inner city and the poor and underprivileged, whether they live in the commonwealth's cities or suburban towns. There is a reason. Today's big-city media reporters come overwhelmingly from a suburban middle-class background. Most of them have no idea of the quality of urban life outside the Faneuil Hall Marketplace and the downtown business district, and regretfully, those who direct them don't insist that they find out. Unfortunately, too, the few minority reporters who work for big-city dailies are, all too often, not interested in covering the low-income inner city, the poor and needy, because power and money in the media lie elsewhere.

There is much still to tell . . . and do. As Kip Tiernan, who is also head of the Poor People's United Fund, told me recently, "Food stamps are not enough; families run out of food stamps before the end of the month. Hunger is still around."

And, although shelter capacity has increased since 1978, many homeless people are afraid of shelters, yet there is no long-range program in Massachusetts to either provide homeless families with subsidized housing or single men and women with single room occupancy in low-budget hotels or rooming houses. In short, what both Massachusetts and most other states lack are transitional programs that will upgrade homeless families and singles from shelters, which lack privacy, to subsidized apartments or rooms.

Part of the craziness is that it costs \$2,700 a month in Massachusetts to house a family in a shelter motel or hotel, whereas for \$500 a month (half paid by the federal government), a family could be located in a market-rental apartment. The fact is that the gentrification of the old rooming houses, combined with the discharging of patients with mental illness from hospitals back in the 1960s and 1970s, has left us

with the enormous and still unresolved problem of hunger and homelessness, and attendant health problems.

Private nonprofits like the Boston Community Loan Fund and the Massachusetts Coalition for the Homeless struggle to improve the plight of the displaced, but it is an uphill struggle. The poverty network and the dedicated men and women, lay and clerical, who support it cannot do it all. The job is just too large. Government has to play a larger role.

There is a crying need not just for a study of what is lacking, but for a long-range corrective program. The initiative to produce such a program should begin in the governor's office, but the media, through some good old-fashioned investigative reporting into hunger and homelessness, could jump-start the process.

Notes

1. Speech by Kip Tiernan at hearing sponsored by Episcopal Diocese of Massachusetts, Faneuil Hall, October 31, 1978.
2. Ian Menzies, "Are Churches Failing City and Its Residents?" *Boston Globe*, November 6, 1978.
3. Ibid., "A Covenant That Offers New Hope," "What Can Be Done About It," *Boston Globe*, October 19, November 23, 1979.
4. Ibid. "A Crisis That Hasn't Gone Away," *Boston Globe*, February 5, 1979.
5. Ibid., "There's Some Cheer This Christmas for Public Housing," *Boston Globe*, December 15, 1980.
6. Correspondence from United Community Planning Corporation, dated August 9, 1982, September 21, 1982, September 28, 1982, November 29, 1982, and March 8, 1983.
7. Ian Menzies, "Just Look Around Us, the Hungry Are There," *Boston Globe*, November 4, 1982.
8. Ibid., "A Response to Hunger," *Boston Globe*, November 25, 1982.
9. Ibid., "The Extent of Hunger," *Boston Globe*, December 16, 1982.
10. Ibid., "One of Those Good Things," *Boston Globe*, February 17, 1983.
11. Ibid., "Words Faster Than Deeds," *Boston Globe*, January 13, 1983.
12. Testimony of J. Larry Brown, Ph.D., of Harvard School of Public Health before U.S. Senate Agricultural Subcommittee on Nutrition, Chairman Robert Dole, April 6, 1983.
13. United Press International news story, *Boston Globe*, December 9, 1983.
14. Benjamin Taylor, *Boston Globe* news story, February 1, 1984.
15. Ian Menzies, "Hunger: It's a Sad Reality," *Boston Globe*, August 4, 1983.
16. Ibid., "It's Faith vs. Hunger," *Boston Globe*, December 15, 1983.
17. Ibid., "To Serve the Hungry," *Boston Globe*, September 13, 1984.

The Needs of Hartford's Homeless Mentally Ill

Steven Kessler, M.D.

A state budget deficit in Connecticut threatens the closing of state mental hospitals and holds the potential of displacing chronically mentally ill patients into homelessness. This article explores the historical association between deinstitutionalization of patients from mental hospitals and subsequent homelessness. One third to two thirds of homeless individuals are mentally ill and require intensive, specific, and targeted responses by the community to end their homelessness. Trends in the care of the chronically mentally ill and the conditions of those who are homeless in Connecticut are explored. Model treatment programs are discussed to suggest possible actions, and recommendations that would help ensure treatment and humane care for the homeless mentally ill in the Hartford region are offered.

In 1990, Connecticut hired consultants Deloitte and Touche to make recommendations on how the state could save money to deal with its deficit. Their report, also known as the Thomas Commission Report, was published on July 26, 1990. In part, the report declared "opportunities for savings and revenue increases," including a savings of \$31 million by closing two of Connecticut's four mental hospitals, along with vague plans to "increase the flow of federal funds" to support the community-based services needed to allow such a shift of patients out of hospital settings.

It is imperative, in my view, that we be certain we do not engage in an action which effectively balances the state budget on the backs of the chronically mentally ill, who because of their disability are unable to fight for their right to decent and humane care. It is all too clear that the past deinstitutionalization of mentally ill patients has resulted in the rise in homelessness among these persons. Hospital care may not have been very good, but at least it provided a minimal level of care. The streets offer none. Indeed, one of the members of the Thomas Commission opposed the hospital closing recommendation because of his concern that this would result in more mentally ill persons "wandering the streets."¹

Steven Kessler, a fourth-year resident in psychiatry at the University of Connecticut Health Center, has begun a volunteer program providing on-site psychiatric service at a Hartford shelter.

Deinstitutionalization

Between 1950 and 1980, there was a decrease in state mental hospital population from about 560,000 to fewer than 140,000 persons as the result of the policy of deinstitutionalization. This policy implied the care of these patients in the community, but such care has been slow in coming and has failed in many ways. There have been many criticisms of the attempts thus far made to treat the mentally ill in the community. The Robert Wood Johnson Foundation program for chronic mental illness is among those attempting to correct these problems. They have attributed the lack of success of these community programs to "the multiple agencies required to the job, fragmentation of funding and administration among different levels of government and between public and private sectors; professional turf battles or disinterest; and lack of administrative sophistication within mental health professions," as well as the difficulties that accompany the arbitrary boundaries of catchment areas."² This fragmentation makes it difficult for services to follow clients, or for services to be coordinated in a reasonably workable way.

In his review of the economic barriers to implementation of model programs for the mentally ill, E. Fuller Torrey ascribes the difficulties to "attempts by various government components to shift the fiscal burden of those services away from themselves," finding a tendency for care to be given based on "what services are fundable and not what services are needed or appropriate."³ He cites evidence supporting his contention that deinstitutionalization is an attempt by states to get patients out of programs that are not federally funded by Medicaid into programs that are. He states that "these actions have been publicly rationalized as promoting community living and a less restrictive environment for patients, but such rationalizations are but a thin veneer covering an underlying economic imperative," concluding that "until the economic aspects of deinstitutionalization are addressed, those services for the seriously mentally ill are not likely to improve significantly."

In their comprehensive review on the subject, Richard Lamb and Leona Bachrach begin their analysis by realistically defining the nature of the population as follows:

Chronic mental patients generally constitute a marginal population with wide ranging service requirements. Most have relatively low levels of psychosocial functioning even when they are receiving highly focused care in the community. When improvements do occur they are generally the result of direct and intensive interventions in specific activities of daily living and tend to be sustained only for the length of treatment. Unfortunately most services set up for the mentally ill were based on acute care models and fail to meet the needs of chronic patients.

This acute care model, although unrealistic, is based on society's desire, based on the American dictum of individualism and independence, not to see these persons as chronically dependent. By fulfilling this desire we fail to meet patients' true needs and improve the quality of their lives. One way this desire has been enacted is by the movement to limit commitment of mentally ill persons, ostensibly to help preserve patients' civil rights. Dr. Bachrach and Dr. Lamb argue that instead, these laws simply limit our ability to help those who need our assistance. Finally, they emphasize that the provision of good community services is not cheap: "Humane concern for the fates of these patients must prepare society to anticipate increased per capita treatment costs."⁴

These and other difficulties of community treatment were well demonstrated by the experience of "second generation deinstitutionalization" at Northampton State Hospital in Massachusetts. There, as the result of a class-action lawsuit, the court mandated an 86 percent reduction in census and the creation of a large number of community residential placements and nonresidential services. Since 1976, with large expenditures of state funds, the hospital has achieved a 49 percent census reduction and a 40 percent decrease in monthly admission rates, but at a higher per capita cost than in the rest of the state. The successes were mostly in placement of geriatric and mentally retarded patients. Younger patients, especially those with a history of repeated hospitalizations, did not seem to benefit. The authors of a review article on the program conclude that "the belief . . . that the requirements for newly admitted patients with acute psychopathology and repeat admission patients with chronic mental illness could be fulfilled by residential environments, nonresidential community services and general hospitals was simply not borne out". They point out that the "underpinnings of the . . . decree were perhaps undermined by a misperception of the nature of serious mental illness itself."^{5,6}

The Chronically Mentally Ill Become Homeless

The psychiatric community has long argued for comprehensive services for the chronically mentally ill. In its 1978 position paper, the American Psychiatric Association attempted to address "the striking inadequacy of care, treatment and rehabilitation of this group, estimated to be one million persons."⁷ A more recent editorial revealed little progress in the intervening decade, stating,

The chronically mentally ill are abandoned, rejected and neglected — in other words they are jailed, warehoused in snake pits, or homeless. Somehow our society is not prepared to commit adequate resources, and it lacks the inner moral authority to ensure that those who are psychologically impaired will be given more than a modicum of food and clothing. There appears to be a denial of the suffering experienced by these patients, and a tacit wish to perceive the homeless schizophrenic individual as exercising a right to be different.⁸

The phenomenon of the homeless mentally ill is the biggest indictment of our failure to care, our choice as a society to let these persons suffer. There are few good estimates of the number of homeless persons. A 1984 estimate ranged from 250,000 to 2.2 million. The Department of Health and Human Services estimated that 33 percent to 66 percent of the homeless in shelters are characterized principally by mental illness, and 25 percent to 35 percent are former patients of mental hospitals.⁹

To better characterize the population, an in-depth study of fifty-three homeless persons admitted to a residential program in Los Angeles for acute and subacute treatment was conducted.¹⁰ Of these, 87 percent had diagnosable psychiatric illnesses: 66 percent schizophrenia, 9 percent schizoaffective disorder, 23 percent major affective disorders, 66 percent substance abuse. Of these, only two had case managers, and none were in outpatient treatment during the time of their homelessness, ranging from one week to nine years. Seventy-nine percent had a history of psychiatric hospitalization. The researchers found that "in every case, severe mental illness appeared to have contributed to the subjects becoming and remaining homeless . . . Present clinically were disorganization and poor problem solving abilities resulting from the illness,

severe paranoia that interfered with or prevented subjects from accepting help, and the depression that immobilized many patients.” Unable to get themselves out of their homeless situation, half of this sample were involuntarily committed to this program. Most had had some treatment, but had been considered “treatment resistant”: not taking prescribed medications, impulsively leaving supervised living settings, and becoming lost from the system. However, many of those committed to this program were later able to enter a community treatment program voluntarily. This led the authors to conclude that “this group cries out to us to set aside our preconceived ideologies, to come face to face with clinical reality, and do what is necessary to provide them with support, protection, and rehabilitation,” including such methods as outpatient commitment, conservatorship, and residential and hospital treatments.

Needs of Homeless Chronically Mentally Ill Persons

A survey targeting homeless users of psychiatric services was conducted in San Francisco to find out what they perceived their needs to be.¹¹ They described their use of emergency rooms or jail as an alternative when they could find no other place to stay. Most of those who were seen by psychiatrists and given recommendations for follow-up, did not act on them. They “tried it once and didn’t like it” or were bothered by specific aspects of treatment, such as lack of anonymity. When asked what kinds of resources they needed to get by in the community, they indicated affordable housing (86%), financial entitlements (74%), employment (40%), free-time activities and social contacts (32%), food (19%), alcohol cessation (18%), supportive counseling (14%), money management (9%), interpersonal skills (7%), and storage space (5%). The authors found a mismatch between the kinds of services offered and those desired. In addition, many respondents complained of barriers to getting resources they needed most. The authors concluded that only when the basic survival needs of these persons are met could they realistically engage in psychiatric treatment.

A number of recommendations have been made over the past decade about the kinds of services that should be provided for this population.^{12,13} They have declared a need for a comprehensive and integrated system of care with designated responsibility, accountability, and adequate financial resources to comprise: housing, including a range of supportive living environments; treatment and rehabilitation services, offered assertively through outreach programs; crisis services; specialized case management by those knowledgeable about the system, these illnesses, homelessness, and able to coordinate care; targeted outreach services; as well as general medical care, family assistance, general social services, legal and administrative procedures such as easier conservatorship status, involuntary inpatient and outpatient commitment, confined long-term settings, training, and research. There was emphasis placed on greater coordination between providers of services, development of programs specifically for the homeless, and the extension of services to prevent the falling through the cracks of those with dual diagnoses.

As Dr. Lamb noted, with a few welcome exceptions “little has been done to implement these recommendations since they were originally published,” that generally “when anything has been done it has too often relied primarily on shelters. Although they are a necessary emergency resource, shelters address the symptom and do not get at the root of the problem; they are only temporary solutions from night to night.”¹⁴

This position has been echoed locally by the Connecticut Coalition for the Homeless, which recently adopted a Vision Statement, setting forth its goal that "we will eliminate the need for emergency shelters by the year 2000 by developing housing and support services to meet each person's needs." They add that "in Connecticut, emergency shelters have grown from three in 1983 to a network of forty-five that provide more than 1,600 beds for shelter each night." They explain how they, "as shelter providers and concerned individuals who have worked to assure that emergency shelter is available to those that need it, we are shocked and saddened by this development." They declare that "we reject and we urge everyone to reject emergency shelters as an acceptable response to homelessness . . . To do otherwise is to give tacit approval to the operative position of our society that it is enough to try to see that no one freezes to death in the winter, and families with children are not on the street."¹⁵ They recognize that this is an inadequate response, but have filled in because no one else has been willing to do so. They have been left to care for our most severely disturbed mentally ill without the resources, training, or ability to do so adequately. The evidence is clear, and we are found morally wanting as a society. We can no longer deny this reality.

The Homeless Mentally Ill in Hartford

Estimates of the number of chronically mentally ill in the Hartford area range from 1,700 to 3,500, although no solid data exist.¹⁶ Although this state has the highest per capita income in the nation, Hartford ranks fourth among all U.S. cities with populations greater than 100,000 in percentage of residents with poverty-level income, and among the top ten cities for child poverty rates.

The capital region has ten shelters for the homeless. In the entire state, from October 1988 to September 1989, 18,449 different people used homeless shelters. Of these 21 percent were women, 44 percent black, 37 percent Caucasian, 18 percent Hispanic. In age distribution, 19 percent were seventeen or younger, 37 percent eighteen to thirty, 42 percent thirty-one to fifty-nine, and 2 percent sixty and over. For income, 17 percent were employed, 18 percent received general assistance, 8 percent Social Security, 8 percent AFDC, 1 percent veteran's benefits, and 28 percent had no income source at all. The most common reasons cited for their homelessness were: family/friend eviction (23%), legal or other eviction (17%), new to the area (13%), substance abuse (12%), loss of income (7%), family abuse (4%), disaster victim (2%), and "other" (22%) (statistics gathered by the Connecticut Coalition for the Homeless). These figures do not reflect persons housed in hotels and temporary apartments (at that time numbering about a thousand), and may reflect a different population that would be found owing to the recession and other changes in the state. In a review of medications taken by 115 shelter users at the South Park Inn Shelter in Hartford, approximately 10 percent were taking psychiatric medications.¹⁷ This is clearly an underestimate of the true prevalence of psychiatric disease among this population, but it does give a sense of the use of the psychiatric system by these patients. Prior efforts to define the psychiatric service needs of the homeless include two surveys of shelter providers in Hartford, in July and November 1988, respectively. In the first study,¹⁸ shelter staff felt that a total of forty-two to forty-seven adults in their facilities (of a total population of two hundred) in a one-week period were thought to have emerging or chronic psychiatric needs. This made for an over-

all rate of 21 percent to 23 percent of clients. Of these persons, more than 50 percent were felt to have a coexisting alcohol or drug problem. Many of them were described as repeaters or regulars at the shelters, and thus account for an inordinate number of shelter bed nights. The November study asked shelter directors to estimate the psychiatrically related needs of their clients over the prior year.¹⁹ The estimated need for services ranged from 5 percent to 50 percent, depending on the shelter. Such estimates, as in the prior study, are based on the ability of shelter personnel to assess psychiatric illness. The figures probably reflect only the most severely ill clients who cause disruptions of some sort. The kinds of services they felt were needed included client assessment, outpatient treatment, case management, and crisis services each for more than 50 percent of these clients. Of the men thought to need psychiatric services only 17 percent were receiving any treatment. Of the women so identified, 33.3 percent were receiving some form of treatment. The most useful services were felt to be those which were on site, rapid, and provided good communication and a sense of cooperation with shelter staff.

Prior Accomplishments and Current Efforts

The extent of homelessness in our capital city is shameful, occurring as it does under the shadow of the governor's mansion and state legislature. As the state begins another round of deinstitutionalization, it must come to grips with its prior failure to provide for the basic dignity and comfort of these persons. The Hartford area has many resources that could, in this time of transition, be used as the building blocks for a comprehensive program for treatment. These resources include public and private hospitals, community mental health centers, a university training program in psychiatry, and a highly trained professional community.

The state of Connecticut has come a long way in the last decade in improving its services for the chronically mentally ill. These include an increased proportion of Department of Mental Health budget going to community services, from 10 percent to 32 percent between 1981 and 1988; community-based residential positions up from 274 to 1,013; case management clients up from 100 to 3,000; 7,000 clients served in crisis intervention; 2,600 clients in Fountain House model programs; and 415 in work services programs.²⁰ However, in its 1989 report, the North Central Regional Mental Health Board cited several remaining difficulties in the Hartford area, including hospital emergency rooms turning would-be patients onto the streets for lack of beds, the inability of state hospitals to discharge patients because of inadequate housing or community services to support them, a case management system serving only 10 to 20 percent of the need, and the lack of a single coordinating agency with resources and authority to implement a managed mental health system.²¹

The state's current actions on homelessness date back to 1982, when the Governor's Blue Ribbon Task Force on Mental Health Policy cited the large need for housing assistance for the chronically mentally ill. An interagency Task Force on Homelessness was established in 1984 involving the Department of Mental Health (DMH). In response, DMH began in the past couple of years to provide funds to fund shelter outreach services from five community mental health centers around the state, including one in Hartford, to provide assessment, referral, linkage to treatment, and support services. In 1990, 207 shelter guests were seen in this program, on which \$207,619 was spent. An equivalent amount was spent on case management

services, and about \$60,000 on drop-in centers, which were to provide some rehabilitation programs. Other funds were used to provide training to those from mental health agencies who work with homeless and mentally ill persons.²²

In the assessment made by the North Central Regional Health Board in 1987, it was felt that some effort had been made to expand services in Hartford, but that "no overall plan exists," and that the steps taken lack "an overall strategy and [are] without specific numerical targets."²³ They go on to note that "no formal effort is under way by the City of Hartford to seek action on behalf of the homeless mentally ill from either the state, the towns, or the private sector." Their position paper outlined a number of recommendations for each of the involved sectors, including: the city: to pursue a legislative program giving the highest priority to the needs of the homeless, to develop a registry of homeless persons to enable tracking, seek appropriate residencies and residential services; regionally: pursuit of a regional approach to the housing crisis involving all surrounding thirty-eight towns; DMH: to pursue accurate and current statistics on the population, to monitor its own discharge policy, to work with other city agencies to review how fully the homeless mentally ill are able to take advantage of their entitlements, and to explore the ongoing need for institutional care for that percentage of the population that will continue to require it; private sector: use of private agencies to provide supervised housing and support housing efforts. Such an overall and comprehensive approach has not been implemented since these recommendations were made. The suggestions, if enacted, would form a solid and systematic basis to enable effective interventions to be made. Such interventions can and should be based on models that have proved to be effective elsewhere as the basis for action here.

Model Programs for the Homeless Mentally Ill

To get a sense of what can be done to meet the special treatment needs of this population, one can look at some particular types of programs that seem to work. I review three types of programs: one that aggressively commits patients, two that use professional volunteer services, and the last being a comprehensive three-phase model.

1. *Getting New York's homeless mentally ill off the streets: Project Help.* This program, begun in 1987, resulted from a program instituted by New York's mayor requiring "the removal from the streets to a public mental hospital those homeless mentally ill persons who were clearly neglecting their essential needs for food, clothing, shelter, and medical care, and who by reason of their mental illness are at risk of physical harm." It utilizes a mobile unit staffed by psychiatrists, nurses, and social workers empowered to order the police to transport these patients to the Bellevue Hospital emergency room for a second evaluation and determination of a psychiatric disposition. The team is notified of most potential patients by a "help line" set up for people to call in referrals. A specialized eighteen-bed, short-term inpatient unit at Bellevue is used for patient evaluation and stabilization, and the system has access to a longer-term state facility, a thirty-bed rehabilitation transitional living facility, and other community residences and support services (case management, computerized tracking system, interagency cooperation). Of 298 individuals evaluated since the program's inception, 84 percent were brought in involuntarily, and half were later transferred to a state facility for extended care. Diagnostically, 80 percent were schizophrenic and 30 percent had a secondary substance-abuse problem. At the end of two years, of the 298 persons, 83

were living in community settings, 80 were in hospital settings, 100 were back on the streets or lost to follow-up, and 2 were known to be dead.²⁴ The authors reviewing the program conclude that it "illustrates how mental health professionals can work with policy makers to develop programs that are responsive to this often neglected, multiply disabled population." Although the outcomes were less than ideal, more persons received care than otherwise would have. One would expect far better results in a smaller city like Hartford, should such a program be implemented here.

2. *Volunteer, pro bono programs.* Critics have charged that a good part of the blame for the deterioration in care for the chronically mentally ill lies with professionals who have abandoned them for more lucrative opportunities. Actually, the American Psychiatric Association (APA) has recommended to its membership since 1988 that they donate 5 percent of their time to pro bono work with underserved populations. The following two programs illustrate the success of such efforts.

The Project for Psychiatric Outreach to the Homeless, Inc. This project began in 1986 as the work of a task force of the American Psychiatric Association New York County Branch. It places about thirty private-practice psychiatrists who volunteer one to four hours a week into one of four community agencies in Manhattan that assist homeless mentally ill persons (shelters, outreach programs, hotels and residences, and a drop-in center). These psychiatrists provide diagnostic assessments, treatment planning, medication prescriptions, individual and group psychotherapy, and follow-up services. The project also provides in-service training to social service teams at the agencies. Since its inception, the project psychiatrists have treated over fourteen hundred homeless clients (more than four hundred in 1990 alone), with a total donation of over \$800,000 in in-kind services to the program. The project was awarded the 1991 Hospital and Community Psychiatry Achievement Award. The program's director, Dr. Katherine Falk, has stated, "Our work has demonstrated that volunteer psychiatrists can make a significant difference in the lives of mentally ill homeless persons," although warning that it is unrealistic to expect that volunteers alone can meet the increasing need for psychiatric services.²⁵

Colorado Pro Bono Mental Health Project. This program, begun in 1986, organizes and coordinates the placement of more than thirty psychiatrists, psychologists, social workers, and psychiatric nurses in the Denver area at any of five sites that serve the homeless, for an average of six hours per month. A nonprofit, independent citizen action group organizes this interdisciplinary effort. The program volunteers have seen more than a thousand homeless individuals per year. Later, a separate pro bono program specifically for high-risk children was developed. This has been a very successful program, a winner of an APA Significant Achievement Award despite its low budget. It has given a rare opportunity for various professionals to work together and be seen as contributing to the care of the most needy.²⁶

3. *A Phased Intervention Approach. The Los Angeles Skid Row Project.* This program, also a winner of APA awards, approaches care at three clinically relevant points: Phase 1: addresses emergency first aid, using a "battalion aid station" model, to attempt to form the first link in a bridge out of homelessness. It includes outreach, drop-in centers to provide temporary safe haven and a focal point for intervention, early identification, liaison with the police, training for shelter personnel, establishment of self-help groups, and the "patching in" of mental health programs into existing structures.

Phase 2 attempts the goal of stabilization, utilizing a "stabilization center" — a five-to seven-day treatment center where patients are cleaned up, rested, given medical

care, psychiatric observation, and evaluation. There they also begin to be linked with appropriate aftercare services, including Social Security benefits, vocational rehabilitation, and counseling; families are contacted and helped to reintegrate the patient. Phase 3 attempts to help patients establish and work through long range solutions, focusing on appropriate housing, benefits, psychiatric care, and case management.²⁷

Recommendations

Our challenge, as described by Dr. Lamb is to “take action without waiting for the ideal to happen.”²⁸ Reviewing the cited programs, we in Hartford can begin to take action. The recommendations should build on those made by the North Central Regional Mental Health Board in its 1987 report, previously cited. The following types of programs should be considered.

1. Integration of current providers of service to the homeless under an umbrella organization so that case coordination and integration of services can be accomplished.

2. Coordination of this organization with the Department of Mental Health and the University of Connecticut to pursue accurate epidemiologic and diagnostic data about this population to better target and assess interventions.

3. A coordinated volunteer professional service, preferably an interdisciplinary one, perhaps under the auspices of the United Way or another independent party, to provide on-site services. An effort should be made to involve as many professional groups as possible, to provide services (psychiatric, social services, and so on), and other representative services (such as legal services to help homeless persons fight for rights and entitlements).

4. Targeted outreach programs based on the Project Help model, with mobile teams that can evaluate and bring persons into an emergency setting. Other outreach programs should be established to include drop-in centers, self-help groups, and the like.

5. Creation of an inpatient program designed for the observation, evaluation, and stabilization of homeless patients as in Phase 2 of the Los Angeles program. This program may be able to take advantage of underutilized existing private hospital space. The benefits of such a program have been documented,²⁹ and the need, as I have learned through my experience, is very clear.

6. Creation and augmentation of outpatient services, especially case management services, so that all chronically mentally ill persons are on the caseload of a mental health agency that will follow them, have sufficient staff to work intensively with them, take full responsibility for individualized treatment planning, link patients to needed services, and monitor them. We should be working toward easing barriers to financial entitlements, easing commitment laws, including outpatient commitment and conservatorship, and providing a payee to patients to help hold and manage their money.

7. A real effort by the city, state, and private sector to ensure adequate housing, because without housing and other basic necessities it is impossible to treat the mental and other illnesses from which these persons suffer. A variety of housing alternatives must be developed, with a range of greater to lesser supervision, or the ability to move from supervised living to independence. Both the client's psychiatric needs, and his or her own preferences need to be taken into account in designing and implementing these options.

Again, as Dr. Lamb reminds us, “What needs to be done is abundantly clear. We need to be bold and strong of will. We must be prepared to mount a large-scale

operation that will give relief to all of the homeless mentally ill. The fate of these persons with such great needs and at such great risk cannot be left in the hands of the faint-hearted."³⁰

In the past, the care of the chronically mentally ill has suffered from naiveté, excessive optimism, and unrealistic expectations about the clinical course of these diseases. The result has been an epidemic of homelessness within this population. Let us rise to the challenge here in Hartford. Before we embark on another round of deinstitutionalization, let us take care to close the gaps in the system that allow homelessness to occur and do justice to those who rely on us to see that they do not have to go hungry and homeless because they are mentally ill. ☛

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Winds Curse

Robert Pavel

I see the tree trunks
Pushing upward
From the ground,

And I know my freedom.

The river coursing
Through its channel
Down to the waiting sea,

and I know my freedom.

The sixty-foot
Vertical rise
Of brick and glass
Surrounded by
A parking lot
Clawing the Earth
To submission,

And I know my freedom.

And then the wind
Gently brushed my eyes
And I knew
That I would never
Be that free,
It comes and goes,
Starts and stops,
And you only know
Where it's been
And never know
Where it's going,

And now I truly know
My FREEDOM.

9/17/2118

Royal Tibetan Date

Robert Pavel is a member of the Portland (Maine) Coalition for the Psychiatrically Disabled. His poem first appeared in File of Papers; Stack of Karma, a collection of poetry published by the Portland Coalition Press. Reprinted with permission.

Aggressive Outreach to Homeless Mentally Ill People

Ellen Nasper, Ph.D.

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Historically, people with chronic mental illnesses have been particularly at risk for homelessness. In 1984, the Connecticut Department of Mental Health (DMH) articulated policy to insure housing for mentally ill persons. One facet of that policy is to increase mental health services to homeless people. The Greater Bridgeport Community Mental Health Center has addressed this need through the formation of the Homeless Outreach Team (HOT). This article describes the development, organization, clinical work, and future of HOT. The team is run jointly by the Mental Health Center (funded through DMH) and Family Service-Woodfield, a United Way-funded agency that provides case management services. Members of the team identify homeless mentally ill persons at local soup kitchens, homeless shelters, and through a network of community contacts. HOT functions by taking clinical services into the community, offering supportive interventions as accepted by its clients. Its success is reflected in numbers of persons housed, psychiatrically stabilized, and participating in rehabilitative services either at the Mental Health Center or through other providers in the community. Several clinical vignettes illustrate HOT's work.

Homelessness is a serious social problem, particularly acute for people with mental illness. Many have insufficient resources to meet the high cost of decent housing. In addition, people with mental illness face considerable prejudice from landlords and neighbors in finding a place to live. Some individuals with serious mental illness lose their housing when they are admitted to a hospital.

The situation was exacerbated during the 1980s, when the federal government abandoned its commitment to the development of affordable housing. At the same time, the purchasing power of persons with serious mental illness, who rely on federal entitlements or state welfare for income, was diminished. Responding to these

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trends, in the early 1980s the state of Connecticut initiated activities that led to the development of services for those at risk of homelessness.

In 1982, the Governor's Blue Ribbon Task Force on Mental Health Policy in Connecticut estimated 70 percent of all discharges from state hospitals would be in need of some form of housing assistance.¹ The dramatic expansion of community mental health services since 1982 by the Department of Mental Health (DMH) has incorporated the recognition that the single most pressing need of individuals who experience prolonged and severe mental illness is housing of acceptable quality. Through the services the department now offers in the community, particularly residential services, a high number of individuals are served who in the absence of such services would probably be homeless.

In 1984, a Governor's Task Force on Homelessness was established in which the DMH has been an active participant. In a 1985 report, this task force concluded that the increased number of homeless persons in Connecticut was due primarily to a lack of low-cost housing and the reduction in federal housing assistance. Responding to stereotypes about homelessness and mental illness, the task force report pointed out that while not all homeless people are chronically mentally ill, a significant proportion do experience some form of psychiatric disability.²

The task force quoted an American Psychiatric Association report on homeless persons with mental illness.³ It concluded that homelessness among the mentally ill was not the result of deinstitutionalization *per se*, but rather of the way deinstitutionalization was implemented: specifically, inadequate services had been provided in the community for people discharged from the hospitals. The report further stated that although caring for severely mentally ill persons in community programs is clinically sound and economically feasible, a vast expansion of community housing and services was needed. Also cited was the need to revamp the mental health delivery system to meet the needs of people with severe mental illness.

Among the observations made was that outreach work is a key factor in providing services and integrating homeless persons into the mental health system. The task force recommended that development of a comprehensive system of care for psychiatrically disabled homeless persons should include outreach advocate workers in each mental health region who would provide both initial service contact at the shelter and referral and limited follow-up services.

DMH's response to the needs identified was twofold. First, residential services were developed as a major priority of extensive community support and psychiatric service system development. Second, and concurrently, there was growing recognition in the mental health field that the housing needs of most individuals with long-term mental illness can be met by accessing the same type of community housing alternatives as are available to the general public. Typically, however, people with severe mental illness have fewer resources and face greater barriers. DMH has therefore increasingly emphasized individualized support services to enable people with mental illness to utilize available housing resources.

The department has also incorporated into its discharge policy the requirement that each patient treated in a state mental health facility have a discharge plan that includes appropriate housing arrangements. Emergency shelters are not considered appropriate housing, and patients are not to be directly discharged by the state hospital to an emergency shelter.

At the same time as efforts have been made to prevent homelessness among people with mental illness by developing residential and other community services, DMH has also focused on establishing and accessing mental health services for people who are homeless and in need of mental health care. First, in 1986, DMH began to utilize a portion of its federal Alcohol, Drug Abuse, and Mental Health Services Block Grant funds to develop a network of new mental health outreach services, targeted to residents of homeless emergency shelters in Connecticut. The thrust of this initiative has been to respond to the immediate needs of emergency shelter residents for mental health services. Integration of residents into the established network of community mental health services is also a major goal where possible. Second, since 1986, state grants have been appropriated each year for case management services to people who are homeless and in need of public mental health services. The core of this program is ready access to mental health and other appropriate support services. Finally, since fiscal year 1987, the Connecticut DMH has been awarded a grant from the Mental Health Services for the Homeless (McKinney) Block Grant.⁴ It allows DMH to participate in the federal program for states to establish, maintain, and evaluate projects for the development and expansion of mental health services to persons who are homeless or at risk of becoming homeless. These services include outreach, as well as community mental health services such as crisis intervention, case management, and supportive residential services.

When McKinney Block Grant funding became available in late 1987, a grant to the southwest region of the state was used to reconfigure services for homeless people with mental illness into one unit, with a focus on mobile outreach services.

In January 1988, the Greater Bridgeport Community Mental Health Center (GBCMHC), a facility of the Connecticut State Department of Mental Health, started a Homeless Outreach Team (HOT). This article focuses on HOT's clinical services, outlining development, staffing, target population, diagnostic issues, and networking. The final section outlines directions for the team in the future.

GBCMHC provides services to the Greater Bridgeport area, which consists of the city of Bridgeport and five surrounding towns. The population of the catchment area is 300,000, while the population of Bridgeport proper is 150,000. Bridgeport has been ravaged by the decline of the industrial Northeast and is one of the state's poorest cities, largely minority, with widespread drug abuse, alarming levels of violence, and shortages of resources typical for inner cities of the Northeast. Bridgeport is in Fairfield County, one of the wealthiest counties in the country.

Homelessness in the GBCMHC Catchment Area

The United Way of Eastern Fairfield County has compiled statistics on homelessness, which indicate that 1,835 individuals stayed in shelters in Bridgeport during the fiscal year 1989. Of these, 872 were adults and their children, 710 single men and women. Fifteen percent who stayed at adult single shelters had become homeless through loss of income, but 19 percent were either fully or part-time employed when they entered the shelter. Sixty-six percent were receiving General Assistance (welfare) when they came to the shelters, 11 percent were receiving Social Security income (SSI, SSD, or retirement payments), and only 5 percent had no source of income. As noted on the fact sheet, these data do not include statistics on persons who lived in the street, in abandoned buildings or cars, or were at imminent risk of loss of their housing.⁵

Structure of the Homeless Outreach Team

HOT offers assertive outreach to clients with severe and prolonged mental illness who are homeless or at risk of becoming homeless. It is a multidisciplinary team that consists of a psychiatrist, a psychologist, a nurse clinician, two social workers, a mental health worker, and three case managers. It is a collaborative effort between a private-sector agency, Family Services–Woodfield (FS-W), and a public-sector agency, GBCMHC. Positions sponsored by Family Services–Woodfield are funded through a federal Stewart McKinney Fund Grant. Positions from the Mental Health Center are funded by state DMH moneys, through matching salary-to-grant dollars.

HOT Intervention and Treatment Programs

GBCMHC and FS-W share responsibility for the HOT caseload. FS-W provides case management services, including case identification, locating housing, obtaining entitlements, budgeting, training in activities of daily living, and transportation. GBCMHC provides clinical services: assessment, diagnosis, counseling, and medications.

Those clients identified by the team who readily accept psychiatric interventions are treated through the usual procedure at GBCMHC — that is, requesting services through the crisis team and evaluation by the Intake program. They are referred either to GBCMHC's Outpatient Services Division (OSD) or to appropriate community agencies. However, other clients seen by HOT are considered to have a major mental illness, but refuse psychiatric services. Such individuals are followed in the community by the GBCMHC HOT clinicians. For these clients, an attempt is made to establish a trusting relationship and provide supportive counseling; case management services, when desired, are provided through FS-W. It is our hope that eventually, as an outcome of our relationship building, some of these clients will accept medications as indicated.

HOT clinicians, to the extent possible, also gather psychosocial data on clients, for several purposes. First, it gives some basis for making a diagnostic evaluation and thus developing a formulation of treatment needs. In addition, it helps sensitize us to the salient interpersonal issues for our clients, especially important because histories of loss are so pervasive among this population: besides losing their homes, many have lost contact with families of origin, spouses, and children. Wherever possible, HOT works to reestablish these supportive networks.

Clinical Services

All clinical services are provided for the HOT clientele by GBCMHC. These include: case identification, psychiatric assessment, triage, medication monitoring, crisis intervention, ongoing medical assessment, and linkage to outpatient, inpatient, and respite services.

There is a significant amount of overlap in the services provided by GBCMHC and FS-W, and this seems to have been useful to the coordinated functioning of the team. Since its creation, GBCMHC clinicians and FS-W case managers have worked side by side in the community. Aware of each other's areas of expertise, they have come to depend and rely on each other, and the team's strength and effectiveness have evolved as its cohesiveness has emerged.

The Need for Role Flexibility

Membership in HOT thus requires significant role flexibility. Clinicians need to be able to function independently, making quick decisions in times of crisis. They must also be patient and adaptable. Assessments can be tedious and difficult with this client population, which is often ambivalent about accepting services. Developing clients' trust can take months. Our effectiveness has emerged through our willingness to do whatever is necessary to engage clients. This has meant diapering babies, finding homes for pets, and establishing bartering relationships with church groups and shelters to obtain needed furniture and clothing for clients. HOT staff are people with high energy and a commitment to the target population.

Interestingly, we have not found it necessary to have a team from the local area, from similar ethnic and cultural backgrounds as the clients, or who have a wealth of experience on the streets. A staff that is sincerely committed to the work communicates this. Clients, in turn, teach staff things they need to know about survival on the streets. However, case managers do need intimate knowledge of entitlement systems in the area and how to negotiate them, as well as patience and flexibility.

While it has always been our goal to have a psychiatrist regularly join the team for rounds in the community, staffing shortages have made this impossible. The team has had to share psychiatrist time with other programs, largely limiting the psychiatrists' participation to consultation by phone from the community, unless clients have been willing to come to the center.

Establishing a Community Presence

We have established ourselves in the community, with both homeless persons and providers through our predictability, constancy, and availability. We make regularly scheduled rounds at the soup kitchens, church suppers, and shelters — both during the day and in the evening. We also make rounds in the downtown area, checking doorways, parks, dumpsters, alleys, and the bus depot. We accept referrals from anywhere. We can mobilize quickly and go wherever we need to in order to serve our target population. We have seen clients in parking lots, condemned buildings, and vacant lots. Rarely do our clients come to the Mental Health Center. We go to them.

Networking

Survival and development of a homeless outreach program relies on community networking, which consists of at least three activities: providing referrals, sharing resources, and pooling knowledge. There is a reciprocal relationship between our referral sources and our resources. Many of our referrals come from other providers, including soup kitchens and shelter staff, local police, jails, the businessmen's council, entitlement programs, and legal aid services. These sources also supply us with a network of resources to assist us in assisting our clients.

Since its inception, the HOT codirectors have sat on the Regional Council for the Homeless, a coalition sponsored by the local United Way. The regional council includes representatives from such diverse groups as the various individual and family shelters, the Department of Income Maintenance, local state representatives, representatives of other local governments, and Legal Services. In addition, HOT collaborates with other health care providers in the Health Care for the Homeless Coalition, which the HOT codirectors currently chair. We have also established relationships with the

Downtown Bridgeport Businessmen's Council, which has provided the team with office space, walkie-talkies, and referrals.

Finally, a critical part of our network is the people of the streets, who are an unending source of information. Street people alert us to others they are concerned about and provide information concerning their behavior and mental status. In addition, familiarity with people on the street enhances the team's safety. Through regular contacts, the street people come to know and respect our work. They are alert to dangers, and some seem to assume a protective posture toward team members and clients. These people are better equipped than we are to teach HOT clients survival skills for the streets. Street people teach one another where to sleep, what public rest rooms are safe to use, and where to get free food and health care.

The Population Served by the HOT

It is important to point out that persons are accepted as clients of the HOT team only if they have refused more conventional psychiatric referral. As mentioned above, a mentally ill person identified at a shelter or soup kitchen who is agreeable to receiving service is directed by HOT to appropriate service providers. They are not followed by HOT if they are willing to pursue services themselves. Thus HOT clients are self-selected by their unwillingness to enter the mental health system by more conventional routes — which might involve walking into the center and requesting that they be seen.

Second, HOT patients may in fact be psychotic, but again by definition they must be functioning sufficiently that on first contact they do not qualify for involuntary hospitalization. When homeless persons are gravely disabled they are hospitalized through some combination of the HOT team and GBCMHC's Mobile Crisis Team, both of which are part of the Community Services Division (CSD) of the Center.

HOT clients typically are minimally compensated: they may be chronically delusional, hypomanic, have significantly impaired hygiene, socially isolative, or experiencing hallucinations, but nonetheless they are minimally functional. They have survived on the street or found minimal shelter. Some HOT clients are marginally employed. None, on first contact, have been found to be receiving psychotropic medications.

Table 1 gives a demographic description of the 61 patients followed by the HOT team since January 1989. (Note: patients are not registered as active with GBCMHC-HOT until after three contacts, when it seems likely that ongoing clinical contact will be maintained. For this reason, our number of active cases has been significantly lower than our actual number of community contacts.)

Two factors surprised us as we reviewed these data. The first is the high proportion of white to African-American clients followed for clinical services by HOT. The majority of homeless persons in Bridgeport appear to be African-American and Hispanic-American. Poverty alone may be a frequent cause of homelessness among the minority population in Bridgeport. In contrast, the white population of this area is largely upper middle class, and includes many extremely wealthy families. The white homeless population may disproportionately include persons whose homelessness is due to poverty, which is a consequence of their chronic mental illness. Non-whites, in contrast, are disproportionately represented among the homeless due to other socioeconomic factors.

Table 1

**Demographics of the Population Served by
the GBCMHC Homeless Outreach Team,
January 1989–December 1991 (N = 61)**

	Category	Number	Percent	
Sex				
Male	36	59		
Female	25	41		
Ethnicity				
White	41	67.2		
African-American	16	26.2		
Other	4	6.5		
Age				
20–29	6	9.8		
30–39	23	37.7		
40–49	13	21.3		
50–59	7	11.4		
60–69	6	9.8		
70–79	6	9.8		
Sex x Ethnicity		Percent Sex	Percent Ethnicity	Percent N
Male				
White	24	66.6	58.5	39.3
African-American	10	27.7	62.5	16.3
Other	2	5.5	50.0	3.2
Female				
White	17	68.0	41.5	27.8
African-American	6	24.0	37.5	9.8
Other	2	8.0	50.0	3.2

We were also surprised at the age range of our clients, especially the number of older persons. Perhaps this speaks to the obstacles encountered by older, chronically mentally ill persons to obtaining housing entitlements. It may also speak to their becoming “invisible” to service providers. Finally, many of our older female clients face poverty common to their age/sex cohort, as the survivors of a working spouse who lose pension supports with the spouse’s death, or as women who have no income following divorce.

Table 2 describes the range of diagnoses of the HOT patient population. We note that as the team is mandated to follow only those clients whose primary diagnoses represent major mental illnesses, persons whose primary diagnoses were found to be mental retardation or substance abuse were referred to other facilities for treatment.

The extent of substance abuse among our client population (totaling 29%) is expected. Indeed, the team is frequently asked to assess persons who appear to be transiently psychotic as the result of substance abuse. We take pains not to include these persons in our ongoing caseload, as their treatment needs can be quite different from those of our target population. The six clients with primary diagnoses of substance abuse who were followed transiently by HOT were referred to other treaters once their primary substance-abuse diagnosis was made.

The most significant source of referrals to HOT has been the Thomas Merton House soup kitchen. It attracts much of the same population as are seen at the shelters, and in addition serves persons who are either entirely homeless, or living in

marginal circumstances and at risk of becoming homeless. The team has established a most important relationship with the soup kitchen staff, who are extremely helpful in identifying persons who may be in need of our services. In turn, the team collects canned goods and clothing, which it offers to the soup kitchen staff to distribute to all clients, regardless of their mental status.

Other clients at the soup kitchen are also sources of referral and information concerning persons the team is already following. It is our practice to hang around in public spaces at the soup kitchen, to assist in serving when needed, to chat casually with people as they eat. In this way we have become familiar to people who depend on the soup kitchen for their nutritional needs. They see us as offering a useful service either to themselves or others.

Table 2

**Distribution of Diagnoses of HOT Clients
Treated at GBCMHC**

Primary Diagnosis	Secondary Diagnosis			
	N	%	N	%
DSM IIIR Axis I				
Schizophrenia (chronic, undifferentiated)	13	21.3		
Schizophrenia (paranoid)	12	19.6		
Bipolar (manic)	8	13.1		
Psychotic disorder (not otherwise specified)	7	11.4		
Posttraumatic stress disorder	5	8.1		
Major depression	4	6.5		
Schizoid/schizotypal personality disorder	4	6.5		
Delusional disorder (paranoid type)	3	4.9		
Organic personality disorder	2	3.2		
Polysubstance dependence	5	8.1	5	8.1
Alcohol dependence	1	1.6	7	11.4
Mental retardation	1	1.6	2	3.2
Pathological gambling	1	1.6		
Dementia			2	3.2

Note: Total diagnoses are greater than 61 because some clients received more than one primary diagnosis.

The soup kitchen also provides space to a medical clinic sponsored by one of the local voluntary hospitals. The medical and mental health providers share information and referrals of clients and have collaboratively assessed several people who have both medical and psychiatric concerns.

Our second most frequent source of referrals is the adult homeless shelters. It is the job of one of the FS-W case managers to identify homeless mentally ill persons at the adult shelters. (Many of the persons identified at Merton House are also seen at the adult shelters.) We have also established working relationships and referral protocols to provide smooth access between the shelters and HOT.

Table 3 indicates the sources that have identified clients to the team.

In spite of our identity as a homeless outreach team, we were struck that so many of our clients were indeed living literally on the street at the time of our first contact. Referral to a shelter was immediately made for those who would accept it; however, as will be illustrated by the case vignettes that follow, not all our clients readily accept offers of housing.

Table 3

Source of Referrals (N = 61)

Source	Number	Percent
Soup kitchen	26	42.6
Shelters (single adult)	17	27.8
Other treaters	7	11.4
Street	6	9.8
Church suppers	2	3.2
Adult protective services	2	3.2
City Hall	1	1.6

Although we have a continuing relationship with the local family shelters, it is notable that none of our caseload has come from them. All but one of our referrals from the family shelters were women with children, many of whom were fleeing an abusive situation (domestic violence and/or sexual abuse), and had symptoms of posttraumatic stress disorder, depression, or both. Those who functioned well enough not to need immediate hospitalization accepted direct referral for evaluation for outpatient services at the Mental Health Center.

In the spring of 1990, we began to offer weekly support groups at each of the emergency family shelters in Bridgeport. As most of the clients in the shelters are women and their children, we made parenting skills and support our initial focus. However, the needs expressed by the clients have had a much wider range, including questions concerning legal and housing assistance and broader issues of problematic relationships and abuse. The group has also functioned for crisis intervention and prevention.

Table 4 indicates our clients' status at the time of their referral to HOT.

Table 4

Housing Status at the Time of Referral to HOT (N = 60)

Status	Number	Percent
Street	21	35.0
Individual shelter	20	33.3
Housed but at risk	11	18.3
Transient hotel	7	11.6
Hospital*	1	1.6

*This client refused all housing referrals at discharge.

Clinical Vignettes

Three vignettes describe the processes of engagement and the results of HOT's interventions with several of our clients.

E.W., a white female, was referred to the team by Thomas Merton House. At the time of the referral little was known about her. She appeared to be in her mid-sixties, was paranoid, thought disordered, hostile, threatening, and verbally abusive. E.W. was rarely seen without her brother, who was protective and apologetic for her behavior. The two of them lived on the street, spending nights in doorways of a downtown shopping arcade.

We remained in touch with E.W. and her brother over a period of approximately three months. During this period, visits varied in length depending on E.W.'s ability to tolerate them. Slowly both she and her brother began to accept us. To our knowledge, neither of these two elderly homeless people was ever married, and both were childless. They became protective of members of the team, as if we were their children. Eventually it became apparent that E.W.'s brother, J.W., was mentally ill as well. He began sharing with us paranoid delusions, which he was adept at concealing owing to the reclusive habits he and his sister had developed. About six months into our relationship with this unusual couple, and about the time they began to consider allowing us to pursue housing for them, J.W. disappeared. The grapevine on the streets told us he had become romantically involved with a woman and gone to New York.

We became concerned about E.W. and her ability to survive, since she had always been cared for by her brother. E.W. now dropped out of sight, and was rarely seen at the soup kitchen. When we did accidentally encounter her, she had become paranoid and verbally abusive again, delusional that a female member of the team was having an affair with her brother and had caused his disappearance. We continued to monitor her mental status in the community. A high-functioning, resourceful street woman (who was also mentally ill) taught E.W. how to survive on the street. She showed her where to sleep safely, where to get free meals without harassment, and what bathroom facilities she could use. E.W.'s condition deteriorated, however, and eventually she was hospitalized involuntarily.

Once hospitalized, E.W. accepted and responded to psychotropic medications. During her hospitalization, HOT referred E.W. to an aggressive case management program at the Mental Health Center. This program was able to arrange for a coordinated program of supervised housing, daily medication monitoring, socialization, and strong supports for psychiatric rehabilitation. E.W. has become an active participant in the newsletter printed by the outpatient psychiatric rehabilitation program at GBCMHC. Poems she writes have appeared in several monthly issues. E.W. has been psychiatrically stable for the past thirty-six months. An active client in treatment with an intensive case management program, she is housed in a family-care home, where she has been for most of this period.

C.B. is a thirty-seven-year-old divorced white male. He was referred to the team in February 1989, also by the staff of Thomas Merton House Soup Kitchen. At the time, C.B. was living in an abandoned car outside his parents' home. His family had refused him entry into the house because of past episodes of violence directed at his mother. During our initial evaluation of C.B., he was dirty, disheveled, smelling of urine, thought disordered, exhibiting loosened associations, ruminations, and tangentiality. It was quite difficult for him to follow a conversation, or for us to make much sense of his. C.B. was unwilling to accept any services from us. However, from time to time he would approach us "to talk" at the soup kitchen, where he was a regular. During these contacts he indicated that he also had a significant alcohol problem.

A few months after we established regular contact with C.B., he was arrested on charges of criminal trespass. Following failure to appear at a court date, he was incarcerated. The team visited him regularly in jail, and during this period C.B. became more open to case management services. We arranged housing for him in a single-room-occupancy house and have continued to see him there frequently. At

this writing, C.B. has been psychiatrically stable for over twenty months, without medications, although old records to which he more recently permitted us access indicate a past history of "revolving door" hospitalizations. While he refuses medications, C.B. has accepted assistance with obtaining entitlements and budgeting, and he uses team members as informal counselors. He has also reestablished contact with his family.

S.R. is a thirty-four-year-old, single woman of mixed ethnic background (African-American, Native American, and white). She was referred to the team by a suburban homeless shelter for men. That shelter had tried to offer services to her, as she had been living in the woods in winter and was grossly psychotic. She expressed paranoid delusions, was extremely avoidant of close contact, and exhibited various compulsive behaviors. S.R. seemed so severely mistrustful that the team decided to approach her with extreme gentleness, but consistent regularity. Three team members individually visited her three days a week, titrating the length of the visit to S.R.'s tolerance. Initially some visits lasted only a few seconds. Over the course of several months, S.R. gradually accepted longer contacts. She continued to be extraordinarily guarded, permitting staff to talk with her from across the room. The thought content she expressed was extremely disturbed, focusing on issues of sexual and child abuse. Although these were described in the third person, we assumed that S.R. was describing in some measure her own experiences of abuse. There were also some reports that S.R. was abusing cocaine.

S.R.'s mental state deteriorated. She was increasingly threatening to others, which culminated in an assault. This resulted in an arrest, and S.R. was sent to the State's only women's prison, some fifty miles from our catchment area. The team visited her at the jail and contacted the jail clinic to request that S.R. be psychiatrically evaluated for treatment purposes and to assess her competency to stand trial. This evaluation resulted in S.R.'s hospitalization for three months. She was medicated, and her cognitive processes significantly cleared. S.R. was discharged to a group home, where she continues to live. She attends the GBCMHC-MICA program (mentally ill/chemical abuse) and has successfully completed three semesters at a local community college.

Outcomes

Complex as their problems are, the disposition of HOT clients is also a complex matrix. As of December 1991, we have lost contact with ten of our sixty-one once-registered clients. We have placed two in nursing homes: both are elderly women who required psychiatric hospitalization but were found to have significant medical problems as well. Seven clients live in single-room-occupancy housing; two continue to live in transient hotels. Six live in supervised housing for the chronically mentally ill. Eight are followed in outpatient programs at the Mental Health Center. Two clients were able to identify resources for private treatment and live privately as well. We are aware of three who remain on the street, two who are in jail, and two who are living with their families. Two were referred for alcohol treatment services and two moved out of state. One client has returned to services in the Veterans Administration system. One client was referred to the Department of Mental Retardation for housing and other services. One is deceased.

Directions for the Future

HOT's future directions, as with all other publicly funded programs, will be limited by the resource limitations imposed on the public sector. Our goals focus, nonetheless, on the expansion of both the nature and extent of our services. HOT has seen a need for a variety of groups that could be offered both in the shelters and the soup kitchens. These groups would be largely psychoeducational, using a model in which gaining information and skills at efficacy will enhance the independence and empowerment of the groups' participants. A parenting education group ran for several months at the family shelter, with some success. Its primary goal was to share information about how to access resources. A client empowerment group, which focused on assisting clients to gain skills to become more effective in meeting their basic needs, ran at the soup kitchen.

HOT plans to collaborate with the Mobile Crisis Unit, particularly expanding HOT availability to include some weekend hours. This will enable HOT clinicians to see clients at the homeless shelters during weekends, when the shelters frequently contact the crisis team about concerns that are actually of a noncrisis nature and should be addressed to HOT.

The addition of a psychiatrist to the team in September 1990 reinvigorated the plan to bring the psychiatrist into the community. Currently, the psychiatrist makes regularly scheduled rounds, seeing clients who may refuse to come to the mental health center, but are willing to be seen and accept medications in the community.

In September 1991, the team was awarded additional money through a grant from the Stewart McKinney Foundation, which has allowed us to create two new positions. One is for a person to teach activities of daily living skills. This person will work primarily in the soup kitchen, providing specialized focus on areas such as hygiene, budgeting, shopping, and stress management. The second position is for an additional nurse clinician with expertise in treating the dually diagnosed (persons with major mental illnesses and substance-abuse problems), an especially frequent problem encountered among the homeless.

The Homeless Outreach Team has functioned since January 1988. Initially it was staffed by persons "on loan" from other programs; the first permanent staff were hired in December 1988. Initially the team was directed by the director of the Intake Program, whose role has evolved increasingly into clinical consultation. The nurse clinician who spearheaded direct services in the community has progressively taken over administrative responsibilities, and became program director in January 1991.

Our experience has been that this close overlap of service provision and administration/policymaking has been vital to maintain the responsiveness of HOT. We have found it advantageous to have the administrative director intimately familiar with the community service providers, shelter staffs, and clients. This maximizes the team's ability to respond to the evolving needs of the clients and the evolving services provided in the community.

In sum, we cite the following factors as critical in the success of the Homeless Outreach Team: intimate involvement with community providers, flexibility in treatment approaches, and innovative treatment planning.

Finally, of course, we simply hope to hold our own in the face of recession, budget deficits, and cutbacks. We expect to see an increased demand for shelter beds as

the result of the poor economic forecast and the predictable losses of jobs, medical coverage, and housing that the poorest of the populations are likely to suffer. The Mental Health Center as a whole anticipates intensified need; HOT will see its manifestation among those who have the least resources to cope. ❧

We thank Melodie Peet, M.P.H., and David E. K. Hunter, Ph.D., A.C.S.W., for their invaluable feedback as this article took shape. We also thank Geraldine January, R.N., B.S., for her support. We acknowledge the shared leadership of Kathleen Lincoln, M.S., and Lisa LaPerle, B.S., former and current codirectors of HOT from Family Services-Woodfield. Finally, we thank for their efforts the clinicians and case managers, past and present, who have made HOT a viable team.

Notes

1. Governor's Blue Ribbon Task Force on Mental Health Policy, *Interim Report* (State of Connecticut, April 1983).
2. Governor's Task Force on the Homeless, *Final Report* (State of Connecticut, 1985).
3. "American Psychiatric Association Task Force on the Homeless Mentally Ill," a report cited in H. R. Lamb, ed., *The Homeless Mentally Ill* (Washington, D.C.: American Psychiatric Association, 1984).
4. Stewart B. McKinney Homeless Assistance Act, Original P.L. 100-77, Revised P.O. 100-628
5. United Way of Eastern Fairfield County, *Fact Sheet on Homeless Single Adults, #4, Homelessness in Eastern Fairfield County*, Spring 1990.

Streets Are for Nobody: Judy Silva

Forty-three years old; working-class family; twice married, five children, six grandchildren. Four years homeless off and on; evicted just before interview, now has apartment.

The movie *The Houses*, you know, it isn't how people lived. They didn't live like that. People live, they live out in the street, they throw a blanket over 'em and that's where they sleep. Ain't no such thing as somebody come and build a little hut for you to live in. No. None a that. I mean, without some help from somebody, people that are homeless are gonna stay homeless. I've been homeless for like four years now. Every time I get a little nest egg set aside, I get a place, well, my income from whatever job I'm workin' don't pay my rent. So I'm back in the shelter again. Like now, I'm back in the shelter again. Again.

I used to do day labor and then I got sick and tired of sitting around waiting to be sent out, you know? You're doin' nothing but wastin' time. And I'll tell you, some of the jobs day labor has — it's one battle after another, you know? And then you find out exactly who your friends are when you become homeless. None of them take you in. Not one of them help you. Not one. And yet soon as they need a favor or somethin', they're right there at your door lookin' for you to help 'em.

See, with my kids, I understand their point, like my son, he's got five kids of his own, you know? And he's got them doublin' up in beds, you know? So, every now and again, I stay on the couch, you know? My daughter, every now and again, I stay with her.

The other day, I was at her house, you know, I went and saw the kids and everything, I was there maybe two minutes, that's all, no more. My grandson Mark says to me, "Nana, y'all leavin' already?" And he started cryin', didn't want me to leave. When Nana gets there, they don't want Nana leavin', and that makes me feel, at least my grandchildren love me.

[She likes her independence.] You know, a lot of times, a lot of people [get] — what they call — institutionalized? What they mean by that is that they get so dependent on being homeless, you know, livin' in the shelters and livin' that kind of a life, they don't wanna leave. I guess after you do [it] so long, you know, strugglin' trying to get outta it — you just give up all hope. But I got good old Italian blood in me and I'll fight until the day I drop. Catch me bein' institutionalized — baloney! I'm too much my own boss. I don't like nobody tellin' me what to do. 🍷

Interviewed by Melissa Shook, April 24, 1990, Chelsea. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

Housing and Services for Homeless and At-Risk People

Newport's Experiment

Mary Ellen Hombs
David A. Mehl

Large and small communities alike have diverse groups of people in need of housing and services: mental health patients, single homeless adults, individuals with substance-abuse problems, the elderly, the mentally retarded, the unemployed, and people with low or fixed incomes. Even with unlimited resources to create necessary solutions, most communities would subscribe to the conventional wisdom of segregating people according to their major needs and managing the resulting environment with a combination of behavioral regulation and casework. In Newport, Rhode Island, an ambitious nonprofit housing organization decided to break those rules and provide a continuum of secure housing choices and support services under one roof.

A few blocks from Newport's mansions and among the expensive residences of its historic district is the home of 150 local citizens without the means to live in this New England city. Fifty Washington Square is a private low-income housing facility that houses people with low-paying service jobs in the city's hospitality industry alongside dually diagnosed homeless people. Since the project's inception in 1988, the nonprofit owners have opened their doors to mental health patients, single homeless adults, individuals with substance-abuse problems, the elderly, the mentally retarded, and the unemployed, as well as citizens whose only dilemma is their inability to afford housing in Newport.

In other communities, these groups would compete for resources and at best be offered segregated facilities and services. Few would consider that the policy of mixing people with such diverse housing needs presents anything more helpful than an expedient solution, and is possibly a recipe for disaster. Newport's unique project has been in operation for three years, with significant costs incurred. Has this social experiment succeeded in its basic mission of providing decent, affordable housing for a variety of people or failed to do more than concentrate diverse problems under one roof?

Mary Ellen Hombs, an advocate for homeless people, is the author of American Homelessness and the forthcoming AIDS Crisis in America. David A. Mehl became the first director of Fifty Washington Square in 1988.

Homelessness and Housing

These are particularly relevant questions for urban communities, given the lack of affordable housing for growing numbers of people. The homeless have become more obvious and their numbers have grown yearly during the last decade; the chief cause has been the lack of affordable housing. Yet often the public debate has focused on the flaws in the emergency and long-term services offered to the most troubled and the most visible: the mentally ill, the addicted, and those who suffer with both, the dually diagnosed. Such a debate overlooks the fact that the homeless are not only those who have trouble keeping housing — owing to mental illness or other problems — but also those who have trouble even getting housing because they can't afford it. Relatively low-paying jobs in the rapidly-growing service sector contrast sharply with high housing costs. Newport's seasonal tourist industry is an excellent example of a local economy that depends on such labor but is hard pressed to provide housing for its workers. The average hotel or restaurant worker would have to pay over 50 percent of his or her income to live in a small apartment — if she or he was lucky enough to work forty hours per week.¹ Affordability in Newport is even more of a problem for a single person with mental health problems who receives a monthly SSI payment of \$471.

In turn, those who have trouble getting housing and those who have trouble keeping it live side by side with the third and largest group, those at risk of homelessness, including both the unemployed and the employed, the elderly on low fixed incomes, the medically uninsured, people with AIDS, and others. In Newport, as in any other city, many people fitting these descriptions are already in the ranks of the homeless, and those at risk may cross over and join them in the space of one or two pay periods. Surveys of those seeking emergency shelter have found that up to 45 percent of the applicants are employed but have lost their housing.²

Newport mirrors the national dimensions of the problem of homelessness. According to the U.S. Conference of Mayors' 1991 annual survey of homelessness in twenty-eight cities, twenty-six of those cited a lack of affordable housing as a primary cause of homelessness,³ and the cities experienced an average increase of 13 percent in requests for emergency shelter.⁴ More than 70 percent of the cities had to turn away families seeking shelter.⁵ An average of 40 percent of those seeking shelter had substance-abuse problems,⁶ and 29 percent had mental health problems.⁷ Half of those seeking aid were single men.⁸

How have communities addressed these problems? Clearly, communities require a continuum of shelter options and long-term support, not just emergency shelter. Large communities have often addressed this problem piecemeal, by creating specialized facilities for discrete populations. In small communities, however, the local population offers up a relatively small number of individuals, many of whom may have only a single need, such as access to an affordable unit or mental health support services. Siting and funding may make it impossible for small communities to create single-use facilities.

The Newport Response

In 1987, Newport faced just such a question after the local YMCA was put up for sale. Nationally, the loss of Y facilities as housing resources has meant some version of

what it did in Newport. In a community of thirty thousand, one hundred people faced the loss of their low-cost housing. Confronted with the prospect of so many soon-to-be-homeless individuals, two Newport nonprofit organizations created a new entity, Fifty Washington Square, Ltd., to maintain one of Newport's only affordable housing resources for single people. Moreover, the parent organizations — Church Community Housing Corporation and Community Development Training Institute — decided that preserving this housing wasn't enough. The partners had one provocative premise which shaped their effort: that in a single building they could provide housing for low-income individuals regardless of the problems they faced, ranging from mental illness to substance abuse to inadequate income. They could help both homeless and housed people get affordable housing and provide necessary services for all these people to maintain permanent housing in the building.

They then sought examples of similar projects in other communities but found none. The problems associated with successfully mixing such widely disparate populations within the same building were obvious. Most of the existing programs they came across were based on segregating discrete populations and applying specific solutions. There was no precedent and much advice against deliberately creating a social fabric as unevenly woven as their proposed project. Nevertheless, they forged ahead with their unorthodox plan.

In 1988, they purchased and started the renovation of the five-story, 58,000-square-foot YMCA building originally built in 1911. The project was financed through the kind of marrying of private, federal, state, local, and foundation funds that became more common during the last decade as communities scrambled to make up for the dire shortage of federal funds. Rather than duplicating existing community social services, the project involved service providers, either by referral or by attracting them to the building. For example, by housing thirty individuals with mental health disabilities, Fifty Washington Square was able to receive both capital housing funds from the state mental health agency and direct residential support services within the building.

A year and a half later, the facility included twenty-three beds of emergency shelter for single adults and families and transitional housing for twenty people in the McKinney Cooperative Shelter and 108 units of subsidized permanent housing, including 70 single-room-occupancy (SRO) units, 15 efficiencies, and 23 one-bedroom apartments. The rent on the permanent units is set at 30 percent of income; the income limit for SROs, which share kitchen and bathroom facilities, is \$13,850. Commercial space on the ground floor and basement levels houses Rhode Island Legal Services, Newport County Mental Health Center, and the James L. Maher Center for mental retardation, as well as the two nonprofit sponsors. Fifty Washington Square brought in the Mental Health Center to run the shelter and hired a management company to operate the entire facility. The owners also insisted that the project's director have shelter experience.

The Housing Continuum

At the core of the Fifty Washington Square housing program is the premise that applicants could move directly into either emergency shelter or the transitional housing program or sign a lease for permanent housing, depending on their ability to maintain their housing and live harmoniously with others. Consistent with the

goal of helping people get and maintain permanent housing in the building, individuals can also move within this continuum of three housing opportunities in either direction based on their own actions and problems.

Bill was a good example of the housing program's ability to help someone maintain housing that he would have lost in almost any other circumstance. Bill was an active and belligerent alcoholic when he moved into the emergency shelter. After he had made a commitment to addressing his substance-abuse problems, he applied for and was accepted into the transitional housing program, where he established a record of stability and sobriety. He then applied for and was accepted into permanent housing. After doing well for nearly a year he had a relapse. His alcohol-related behavior once again became so intolerable that, faced with eviction from his permanent housing, he left voluntarily. Unlike any other landlord in the city, Fifty Washington Square was ready to offer him a chance to return to the transitional housing program, which he accepted. He subsequently reestablished his sobriety and again signed a lease for a single permanent unit. In the course of the eighteen months of this sequence of events, Bill kept permanent housing for ten months and utilized the McKinney Shelter during the balance of the period.

While the theory of a housing continuum was being borne out, the project was experiencing other critical problems, including high turnover rates in portions of the permanent housing and a high vacancy rate leading to subsidy and operating losses. The annual turnover in the single rooms was more than 65 percent. Permanent residents with leases included approximately 35 percent with mental health problems, 20 percent with short-term disabilities who were on public assistance, 30 percent with substance-abuse problems, 10 percent elderly, and 40 percent employed in low-paying service industry jobs. The emergency shelter included approximately 50 percent transient homeless and 50 percent individuals with chronic mental health or substance-abuse problems.

The Social Matrix

Despite these initial problems, the project was witnessing positive dynamics which suggested that broader goals were being achieved. Residents were reacting to their neighbors in the building in a way that greatly enhanced the effectiveness of the project. Their experience and understanding of their own housing dilemmas almost always led to empathy for others. Their acceptance of others and often markedly different life circumstances were forming a social fabric that strengthened the sense of community in the building.

Where the building's owners had first perceived random social relationships within the building, they now saw a complicated but identifiable dynamic within the residents' interrelationships. There was in fact a matrix of social interactions that was playing a dominant role in forming the building's personality. This matrix consists of two components: the segments of the housing programs, which are primarily defined by administrative rules, and the range of residents' personal circumstances, primarily identified by behavior, which have presented obstacles to acquiring or keeping housing in the past. The matrix of different but frequently shared problems within all three housing programs in the building develops a complicated social fabric that could easily create

formidable obstacles for the simple management of the building, let alone meeting some of the more ambitious goals of the project.

For example, all three of the housing programs — emergency shelter, transitional, and permanent housing — include residents with mental health problems. Not only do residents sometimes have more than one issue at work in their lives, but no group of residents with a similar problem is neatly confined to one category of housing. Thus, building management and mental health case workers alike must relate to people with similar problems in different living situations within the building.

Similarly, residents establish relationships that cross over housing program borders which impose different rules for different residents within the same building. The clarity that comes from distinct categories is missing, presenting an ambiguity to which both residents and staff have to react.

Parallel situations existed for other elements in this matrix: substance abusers, elderly, those with no or inadequate income, and so on, represented within all three housing programs. This overlay of types of housing and people was an intimidating mix for the building management. Fashioning rules and services for meeting the facilities' goals looked difficult at the start.

The Social Fabric

The opportunities for miscommunication, confusion, and perhaps, chaos seemed significant. However, they rarely materialized. Management had initially thought it would probably play the largest role in determining the building's environment. Slowly it became apparent that the dynamics of the matrix were contributing as much, if not more, to the positive atmosphere. The building's air is remarkable for its friendliness and informality. Compared to many conventional apartment buildings, it encourages an unusual amount of positive interaction among the residents. They participate readily in light social conversation, even with those they do not know well. There is a sense of pride in the environment, one indicator of which is the extremely low incidence of vandalism.

Two major factors contributed to the success of this social fabric. First, despite the broad differences in many residents' lives, their common dilemma in finding affordable housing created an empathy that greatly enhanced the self-identity of the building. Fundamental to this was the residents' understanding that a lack of tolerance for others could lead to their loss of housing in the building or even to homelessness. Residents' intolerance of others' behavior was in certain respects no different from what one would find anywhere else, but any resident's negative reaction to the specific problems of others was frequently overridden by the common understanding of homelessness.

Roberta is the most disruptive and delusional women's shelter resident. Because the women's shelter is in the heart of the permanent residences, Roberta has occasion for frequent contact with many of the building's 110 permanent housing residents. Her pattern of verbal provocation of others led to numerous confrontations with John, an otherwise calm leaseholder in a single room. In a conversation one night in the second floor TV lounge, John led a contingent of residents who were adamant that Roberta should be denied housing in the building because of her behavior. The most striking part of the conversation occurred when it was pointed out that the consequences of such an action would result in Roberta becoming homeless. John,

who had been the most vociferous in espousing her removal, at that point said simply, "I didn't know that. That changes things." John abandoned his previous position, and the entire nature of the conversation changed.

Second, personal relationships also tied the housing programs together. As residents left emergency shelter and moved into transitional housing, they maintained friendships with other emergency residents. Those friendships frequently became the pathways for others to progress within the building.

Red, a man in his fifties who has been homeless much of his life, moved into the emergency shelter seven months ago. After a three-month stay, he signed a lease for a single room. Joe, who became friends with Red while they were both in the shelter, began to visit him upstairs regularly. Red has indicated to management that he hopes Joe, who currently has a drinking problem, will eventually be able to move upstairs.

Similar relationships existed between people in the other housing programs and served to communicate the project's goals and enhance their fulfillment in ways that management could never hope to achieve. Their empathy and the personal relationships that exist within this matrix turn out to be the strongest parts of the social fabric; diversity has not been a source of chaos in the building.

Breaking Rules

How did management respond to these developments? They looked for ways to build on the positive aspects of the residents' relationships. Management decided that although the differences among the three housing programs were real, the benefits from interaction among the residents were significant and so strong that management would not retreat from its commitment to house and support such a wide variety of individuals. In fact, management took additional steps to minimize the divisions between residents on a personal level.

Cautiously at first, then more boldly, they actively worked to achieve the most porous administrative delineations possible among the programs. When the project started, residents with mental health disabilities were segregated on the third floor. They are now randomly housed throughout the building's permanent units. Nor are the residents segregated according to gender on the building's floors. The women's and family shelter is located in the heart of the permanent housing portion of the building and shares kitchen facilities, lounges, and entrances with permanent leaseholders.

Although 70 of the 108 leased units are single rooms and structured like a rooming house, they are operated like any other apartment building. Permanent residents have all the rights and protections of Rhode Island tenant law; they have their own keys to the building and come and go as they please. They may have visitors at any hour of the day; there is no discrimination toward homeless residents visiting their friends in permanent housing. Management also became less risk adverse in screening applicants for its residential programs. At one time or another, all these steps seemed to be risky, but all have proved to be integral and important parts of the program.

In addition, management has evolved a hiring program for residents; currently seven of the nine staff members are residents of the building. The staff includes four people who operate the front office twenty hours per day, seven days a week. Their

duties, which vary, include collecting rent, processing the subsidy paperwork, responding to residents' questions or problems, providing building security, and handling emergencies. The building also has a maintenance staff of four people. The director handles overall management and performs resident support functions for the 112 permanent residents. The shelter is administered by the local mental health agency, and its staff includes one and a half case managers. In addition, management has created a floater crew of residents who, while not employees, are used on a rotating weekly basis to staff the front office. These residents are trained by management and perform many of the management duties of permanent staff.

Measures of Progress

Management's earlier concerns about housing disparate populations and their impact on more traditional measures of performance — turnover, occupancy level, rent collection — were likewise assuaged. Occupancy reached capacity levels eighteen months into the project, and turnover now remains at three to four units per month, which reflects national rates for single-room occupancies. Perhaps most surprising, rent collection has not been negatively impacted either by turnover or by preconceived notions of what role bad debt might play in the building's operations. Most residents are not in a position to offer monthly rent payments or payment by check; therefore management must accept weekly payments, frequently in cash. In addition, continuing informal negotiations take place to accommodate rent arrears; security deposits may also be paid in installments. At any one time, the project has \$2,000 to \$3,000 in rent arrears. Although such flexibility in rent collection practices requires considerable management time, it is a crucial part of the building's success in meeting its goal of helping people keep their housing. However, this flexibility does not translate into losses for the project. Last year, the more than \$140,000 in tenant rent collections resulted in only \$116 in bad debt from tenants who moved out of the building.

With a strong social fabric in place, management has sought to start programs in the building that would allow occasions for greater resident interaction with a minimal amount of staff involvement. A writers' group meets regularly and publishes both a literary magazine and a building newsletter. A Residents' Building Committee that meets monthly to make recommendations for building improvements has an annual budget of over \$1,000 to spend as it sees fit on such improvements. Alcoholics Anonymous and Narcotics Anonymous meet regularly in the building. A literacy volunteer program comes to the building weekly, and a veterans counseling program provides semimonthly services on site. A new employment assistance program has started.

At the same time, the project does not provide an environment to meet everyone's needs. For example, there is no residential substance-abuse recovery program at Fifty Washington Square, nor is there a permanent housing component for people with limited independent living skills. Further, given the transitions necessary for some residents as they move into the building and along the continuum, it was a realistic step for the owners to decide to physically separate the men's shelter from the rest of the building.

Newport's experience with integrated housing programs for low-income individuals suggests that this seemingly chaotic social mix is far from a disadvantage but rather is a source of much of the project's strength. Indeed, an argument could be made that the

success of the project is increased by the diversity of its residents, in contrast to the risk incurred with a discrete population. The degree to which the building duplicates the outside world is an asset for its residents as they move through the continuum.

Fifty Washington Square shows that *how* services are delivered is as important as *what* is delivered. If management had accepted conventional notions of people and their problems being one and the same, they would not have been prepared to operate the building on the same premise that commercial housing projects do: that people are judged by their behavior and not by other categories or labels they bring with them. Instead, management defined for itself and the residents two very explicit rules and adhered to those as priorities: rent must be paid on time, and residents must behave in a way that is respectful of others in the building. The success of the project and the large variety of people it serves suggests that the owners' original vision and management's frequent leaps of faith can be translated into similar successes for projects offering single or multiple services in small or large communities. ♪

Notes

1. One-bedroom apartments in Newport rent for an average of \$400 to \$500 per month, and average monthly income for a full-time worker at \$5.00 per hour is \$860. The federal government considers housing to be affordable if it consumes no more than 30 percent of a household's income, meaning that a Newport worker would ideally pay no more than \$261 in rent. National trends indicate that 56 percent of poor renters, or 10 million people, pay more than half their income for housing, creating a pressure called shelter poverty. See generally, Center on Budget and Policy Priorities and Low Income Housing Information Service, *A Place to Call Home: The Housing Crisis for the Poor Continues* (Washington, D.C.: December 1991).
2. U.S. Conference of Mayors, *A Status Report on Hunger and Homelessness in America's Cities: 1991* (Washington, D.C.: U.S. Conference of Mayors, 1991), 62.
3. *Ibid.*, 35.
4. *Ibid.*, 25.
5. *Ibid.*
6. *Ibid.*, 62.
7. *Ibid.*
8. *Ibid.*

The Story of My Life

Betty Reynolds

I Betty Ann M. Reynolds, was born in Fall River, Massachusetts, on February 10, 1954. I had a pretty good childhood but when I was five years old I was rushed to the hospital to get my stomach pumped because I ate a whole bottle of aspirins (because I thought they were candy.)

At this time we lived on Long Highway, Little Compton, and we had to travel all the way to Fall River for the hospitals. We lived in a house made out of garage doors. We lived there till I was a teenager. Then we moved to Howard Street in Fall River, Mass. We stayed there until I finished high school.

We moved to Newport, R.I., where my sister met and married her husband. Right after, I met my first husband. He wanted to take me to Massachusetts to get married. I was married to him six years. I had two beautiful children, a boy and a girl. Also, I went through a lot of beatings from him, and took it because of the kids. Their names are Dawn Marie, aged 10, Joshua Edward, age 9. In March of '83 I got my divorce from him and at the same time the lawyer told me I had to give him custody of both the kids.

I was so upset that I went to the bar and got drunk. I was a drunk for almost a year, till a friend got a hold of me and told me to stop drinking or he will kick me right square in the butt. That friend was a Mr. Hawkins and till this day I haven't touched a drink.

Then, in the year '85 I met my second husband, and we got married. The first month and a half was fine, till he started to hang around with his brother and started to drink. One day he got drunk and flipped out and I got a wicked beating, so I left him. He came looking for me and asked me to come back and he was sorry. I went back and stayed a week. He got drunk again and beat me up again, so I left him again. Also, I got a paper saying that he couldn't come near me or he would go to jail.

I was married to him a total of three years. Then I got a divorce from him in '88. Right after that, the same year, I got married again. I was with my third husband for a little over two years before — well, guess what, right after I said, "I do," the shit hit the fan.

Betty Reynolds is a resident of Fifty Washington Square, Newport, Rhode Island. Her work has appeared in In the Heart of the City, a literary magazine produced by the residents of Fifty Washington Square. She loves "to write short stories and poems."

I got beatings after beatings, and it went on for a year. I finally got sick of it and left him in the beginning of October of '89. Now I am working on getting a divorce from him.

On October 13 of '89 I met a wonderful guy in the building. He treats me like a queen and he does a lot for me. I've been going with him for six months now. Since I've been with him I have received three diamond rings and some other things that mean a lot to me. Maybe some day I will get married again but for now I'm enjoying being spoiled all the time. ♡

4/16/90

Rural Homelessness in the Upper Valley

David Shumway

“Rural Homelessness in the Upper Valley” is about the problems and advantages small shelters in the Upper Connecticut River Valley have in working with the homeless. Unable to compete with urban shelters in pursuit of federal and state emergency shelter funding, Headrest, in Lebanon, New Hampshire, demonstrates that its smallness has been turned into offsetting advantages. The quality of Headrest’s case management with homeless clients and sincere efforts to network and interact cooperatively with other social service providers, ecumenical groups, and other members of the community have led to significant new community initiatives. Details of recent Upper Valley successes in forming coalitions to work on improving services to the homeless and the start of a free medical clinic are presented.

In 1988, our efforts to raise community consciousness about rural homelessness started with the catchy question, “Homelessness . . . If you think it’s only a big city problem, think again.” In fall 1991, the theme was more along the lines of “Rural homelessness is here in the Upper Valley . . . just look around you.” Look at the number of people who show up for community dinners, look at the numbers of people our shelters are turning away, look at the number of pages of real estate foreclosure and auction ads in the papers where there used to be pages of help wanted ads.

Rural homelessness is still not as obvious as urban homelessness, however. We still have very few people we would call street people as we see in larger cities (Nashua and Manchester, New Hampshire, and Burlington, Vermont, being our exceptions). In our talks to community groups, we get this point across by saying that because we don’t have people sleeping on subway grates, we are not so aware of the homeless in our small towns. Homeless people in our area, the Upper Connecticut River Valley region that stretches from Claremont, New Hampshire, to Bradford, Vermont — and includes the very affluent towns of Woodstock and Norwich, Vermont, and Hanover, New Hampshire — live in cars, in seasonal campgrounds, abandoned mobile homes and buildings, and even the woods.

David Shumway is director of Headrest in Lebanon, New Hampshire.

Service providers in our area as well as the New Hampshire Division of Mental Health, administrators of the state's emergency shelter money, are in agreement on the magnitude of the problem. Our view is that between two and three people per hundred of our population will be homeless at some point in 1992. These are the people we can count, the ones who come forward and seek shelter or emergency assistance. We hope the old estimates that four out of five homeless individuals never appear at the doors of a shelter are no longer true. Our greatest fear is that it is still so.

The many social service agencies that belong to the New Hampshire Coalition for the Homeless were dealt a cruel blow by the U.S. census takers in 1990. The Census Bureau planned to count all the homeless in the state by designating one day and evening to get out to the places where the homeless "congregate." Shelter administrators received a series of calls, in the weeks preceding the event, asking us to identify all the places the census takers should go to count the homeless accurately.

When the big day came, the weather was what you sometimes get in northern New England — cold, raw, and rainy. That terrible evening saw one census taker come in the front door at Headrest, talk briefly with the two homeless clients sitting at the kitchen table, and leave. Eight people were staying in our shelter that night, though most were out at an Alcoholics Anonymous meeting when the census takers arrived. They left no forms to fill out, did not check in with the Headrest administrator on duty, and as far as we have been able to tell, did not go to any of the places in the field we had told them they would find homeless people. We are also told that the census takers did not visit any of the shelters for battered women in the state! It seems incredible that a rainy night could keep the U.S. Census Bureau from getting it together to carry out their mission of counting the homeless, and even more incredible that their sorry performance was part of the basis for the numbers Jack Kemp's Department of Housing and Urban Development uses to discount the magnitude of the homeless problem in America.

We know that the "homeless with a roof" population is growing steadily, and these folks are especially hard to count. They include individuals, couples, and whole families who drift from one acquaintance's home, apartment, or trailer to another. They wear out their welcome at one place and move on to the next relative or friend who will take them in — "Just until my check comes in" or "Until they have work for me out at the plant." This category also includes young females, many still in their teens, who stay with an alcoholic and abusive older man, putting up with his sexual demands, in exchange for a place to stay.

The picture also includes homeless teens who might be staying with a friend's family just to get through the school year and finish work for their diploma. In 1989, one rural school in our area, Mascoma Valley High School, had fifteen homeless students in the course of the school year out of a total enrollment of four hundred. "Homeless with a roof" also includes large numbers of people living out on the back roads in many of our rural communities, in shacks and rundown ramshackle buildings and trailers. The ones who have plumbing struggle all winter to keep the water pipes unfrozen and to generate enough heat to keep their children or elderly relatives safe.

Working with the homeless in smaller population rural areas puts service providers at some distinct disadvantages compared with large shelters in urban areas. We cannot, for example, qualify for comparable amounts of government funding in support of shelter programs, nor should we. Dealing with a homeless popula-

tion that can reach two or three per hundred in an area of fewer than fifty thousand total population just can't compare with urban areas that have similar percentages in a metropolitan area of a million or more.

While our access to public funding sources is understandably less, it is the purpose of this article to demonstrate that service providers in our situation have some real advantages as well. If we do effective case management with our homeless clients, and we can still do that, and work with other agencies and community groups in honestly cooperative efforts, there is much we can do to have an impact on the complex problem of homelessness in our rural areas.

The effort social service agencies are making in the north country to work effectively with the homeless is being played out against the backdrop of a steadily worsening New Hampshire economy. Our tasks are made harder by the fact that there seems to be little real hope that the ultra-right wing, no broad-based taxes death hold of the only statewide newspaper will be broken soon. In the fall of 1991, New Hampshire found itself beset with increasing unemployment associated with a shortage of jobs, especially in the areas north of the "golden triangle" of Nashua, Manchester, and Salem.

New Hampshire is number one! That's right, but it's in categories like the per capita rate of new personal bankruptcies and the per capita rate of new food stamp applications. Ominously, the National Beer Institute ranks New Hampshire at number two in the nation when it comes to per capita beer consumption. As an outgrowth of the "no broad-based taxes" theme, and with serious implications for the state's ability to prepare its sons and daughters for the challenges of life in the 1990s, New Hampshire ranks fiftieth in the nation in per capita state aid to public education. We are told that New Hampshire could spend three times what it does to support public education and still rank fiftieth! Maybe there is some perverse truth in current topical humor to the effect that Mississippi recently increased its spending on education in order to avoid being known as the New Hampshire of the South.

There are fewer than five hundred beds in all of New Hampshire's thirty shelters serving the homeless, including women who are homeless by reason of domestic violence and are staying in shelters or safe homes for battered women. In 1990, 8,684 individuals stayed in these shelters for periods of one day to several months, while another 3,300 were turned away, primarily for lack of space. The New Hampshire Emergency Shelter Commission, under the auspices of the Division of Mental Health, counted another 12,600 people who came forward for placement/prevention nonshelter services.¹ The best way we have heard to put these numbers in perspective is to cite Henrietta Charest, president of the New Hampshire Coalition for the Homeless, who has frequently said, "The best analogy I can make is that if there were nine thousand last year in New Hampshire's thirty-plus shelters — that's no better a look at who's homeless than if you go to all the hospitals in the state and count all the people in hospital beds. That's not a count of who's sick. That's a count of people who are in the hospital."²

The rural homeless in New Hampshire are represented by people from all walks of life. They are families, whole, intact families and broken families, with dependent children. New Hampshire's homeless population includes teenagers and the elderly, often alone and sometimes with another person. We see couples, married and not, struggling to stay together against all odds. Then there are the single people, some

of whom are female, but the overwhelming majority are the most troubled of the homeless population — single men.

There are among the homeless we have gotten to know many developmentally disabled individuals, as there are emotionally and mentally ill people. There are dual diagnosed persons of many stripes, and there are the oppressive numbers of homeless individuals with substance-abuse problems. At Headrest, where we primarily take in single people, some couples, and teens when there is nowhere else to place them, it has been our experience that at least 60 percent of the people we serve in the course of a year have an alcohol or other drug problem that has contributed to making or keeping them homeless. For many, an addiction is the *primary* cause of their economic misery.

An increasing number of the people who have come to us for help are simply the unfortunate victims of hard economic circumstances. We take great pains to raise the public's consciousness about homelessness in our area by stressing that perhaps many of us are not so far removed from a financial disaster that could drastically change our circumstances. We participated in a program at Dartmouth College that discussed homelessness in its many aspects. One of the points we made that hit home the hardest with our student audience was the information that in the past year and a half, *three* Dartmouth graduates have been staying for short stretches in our small shelter in Lebanon. The message is clear: if it can happen to Ivy League graduates, it can happen to a great many people who never expected to find themselves homeless and seeking shelter.

In our area, the tasks of working with the various segments of the homeless population are divided among several social service agencies. Families and women with children are referred to and served by the Upper Valley Haven in White River Junction, Vermont. Case management for people staying at the Haven is performed by our good friends at SEVCA, Southeastern Vermont Community Action. Women who are homeless by reason of domestic violence are the primary responsibility of WISE, Women's Information Service, in Lebanon. Our sister agency in Lebanon, LISTEN, dispenses emergency services, operates a thrift store, a food pantry, puts on community dinners, and offers budget counseling to the disadvantaged.

Headrest, with its strong substance-abuse counseling and crisis intervention orientation, again, primarily serves single people, of which 80 percent or more are single homeless men. Because our case management at Headrest involves the unique and never-ending problems of homeless single men, we will give this group special attention here.

From our standpoint at Headrest, the problems of homeless men are in many ways more frustrating than problems women and families have in the same circumstances. It is generally acknowledged that our federal and state welfare systems are designed primarily to aid women with children or whole families. While the way the system really works has the effect of degrading and humiliating many of the people who seek some form of public assistance, women with children, especially, ultimately succeed in arranging minimal amounts of assistance in the basic necessities for themselves and their dependents. We have no quarrel with that as a priority. Our very considerable frustration is not having programs or resources available to serve men who are unable to help themselves.

More men than women wind up on the streets for many reasons. For starters, there are women who will make whatever compromises necessary to avoid it, like

the teenagers mentioned earlier who stay with alcoholic and abusive older males to avoid being homeless. Second, shelters everywhere have more accommodations for women and children. In fact, Headrest's small shelter that takes in 80 percent single men is unique in New Hampshire. Third, in general, women are better at asking for help than men. Fourth, low-paying service-sector jobs that have replaced manual labor in the economy go mainly to women or high school-age kids, not the single men who at one time did some of the hardest and least desirable jobs.

Homeless men in northern New England, too, are often the products of a pattern of failure that has become too prevalent in America. They may have experienced failure in school, for hundreds of different reasons. Many of these adolescent males dropped out in disgust and took their rebellious acts on the road. Abusive, codependent, or neglectful family life have produced runaway and throwaway teens and young adults. Many more young men have been sent off to fight in foreign wars during the past thirty years, with disastrous results as they returned in various stages of emotional, chemical, or physical chaos. For as many as 60 to 70 percent of these single men, the marginal life they have either sought or fallen into has held another trap for them: substance abuse and its insidious addiction to alcohol and other drugs.

One way or another, these men wind up in desperate circumstances, but in America men are neither supposed nor allowed to be dependent on society. The cultural bias most Americans impose on men is that they are expected to take care of both others *and* themselves. If they are not capable of taking care of themselves, whether at all or for a short time, the assumption most Americans make is that they are less than men and therefore unworthy of help. The single most severe cultural prejudice we come up against as social service people trying to raise the public's consciousness about homeless issues is the emphatic claim that these people are all lazy, and if you give them help or material assistance they'll just keep "sponging" off the rest of us.

We often ask our audiences to consider this: if we were to pass a small group of homeless women on the Lebanon Green, or Boston Common, or on a street corner anywhere, wouldn't most Americans tend to see to them as victims and wonder what awful things must have happened to them to put them in their homeless condition? However, if we were to pass a small group of homeless men in the same situation, wouldn't the reaction of most of us simply be fear? Isn't it true that when most of us see homeless or idle men, we sense or imagine danger?³

Men are also expendable in our society. As Peter Marin points out, "When men work (or when they go to war — work's most brutal form), we grant them a right to exist. But when work is scarce, or when men are of little economic use, then they become in our eyes not only superfluous but a danger."⁴ Further, "And while it is true, in general, that men dominate society and women, in practice it is only *certain* men who are dominant; Others, usually those from the working class . . . suffer endlessly from forms of isolation and contempt that often exceed what many women experience."⁵

Society has a hard time seeing single homeless men as victims of circumstances and hard times. Although both male and female children are permanently injured by abuse and violence and cruelties in families, somehow we find it hard to see that grown men can also be crippled by childhood and end up on the edges of society, unable to play expected roles in a world that has betrayed them.

Working with homeless single men, we are often struck by the anger and despair many of them have about whatever has happened to them. Most of us — men and

women — grow up expecting that when things go terribly wrong, someone, from somewhere, will step forward to help us get over the problem. That this is just not going to happen because there really is no one there for them is perhaps the most frustrating discovery an impoverished person can make.⁶ This is why there is so much anger in some homeless single men when they finally come to a shelter for help. When they have needed help the most, there has not been anyone there to help them pull through their private version of rock bottom.

Many different kinds of services are being provided for the homeless and nearly homeless in the northern half of New Hampshire. The Tri-County Community Action Program (CAP) does a marvelous job, with extremely limited resources, of making emergency services available, including fuel assistance, advocacy on various prevention issues, and supplying food and clothing to those who need it most. Case management at the CAP agencies can involve helping clients understand what benefits are available and how to apply for basic necessities, negotiating with utility companies and landlords when clients cannot pay for themselves, and helping with job searches and the mountain of bureaucratic red tape poor people encounter in the system.

Agencies also face a daily effort to help their disadvantaged clients work out problems in arranging transportation. This hardship usually receives scant attention from funding sources and researchers. Transportation represents an aspect of rural poverty that is rarely a major factor in urban areas. However, out in the country it is a long way to the services poor people need, and figuring out how to get from one place to another is one of life's oppressive daily dilemmas for the homeless and nearly homeless. Unfortunately, with the exception of too few and too far scattered volunteer driver networks, we have not been able to provide consistent answers to people who are unable to get around easily.

To illustrate, we can relate the story of a young woman who called to ask whether we knew of any funds to help people with maintenance problems on their cars. It seems that her old clunker of a car had blown the transmission over the weekend, and she was afraid it would cost the equivalent of two months' rent to get it fixed. Her choice, therefore, was between paying her rent and keeping her place to live, or repairing her car. She lived in a trailer on an unpaved road four miles from the village of her town. She needed to take her three young children to her only day care option eight miles away, then reverse her course and travel twenty miles to the New Hampshire Vocational-Technical College in Claremont. Because she was enrolled in a special program for disadvantaged and unskilled women, she was not allowed any class absences.

This woman was obviously trying as hard as she could to improve herself as a possible way out of a cycle of poverty that took her perilously close to homelessness. But every day was a struggle, and every day her self-esteem took another pounding from a system that made life as hard as possible for her. The sort of transportation hassles she had to solve every day would have defeated many people. We were able to refer the woman to an auto mechanic who had told us that he would try to help truly needy cases with their auto repair emergencies, and tapped into the Salvation Army voucher system for a small assist with the repair bill. Headrest's case workers were very frustrated by not being able to find any more resources for the woman.

When all the prevention and public assistance efforts of Tri-County CAP, of LISTEN in Lebanon, of Rural Community Action Ministries in northern Maine⁷

have failed, there remains emergency shelter at the few rural agencies with overnight bed space. This is where we see that rural shelters have some distinct advantages that one might not expect over their larger urban counterparts. The smaller size of our shelters, the low number of beds available to homeless individuals and families, simply means that we can count on our lodgers to be serious at all times about working with us to resolve the factors that led them to become homeless.

At Headrest, a maximum length of stay is not written into our lodging rules. Instead, we let lodgers know that a prerequisite for their being able to stay more than one night in our shelter is a commitment to work with our shelter coordinator to try to turn things around. We point out that our bed space is extremely limited, so we cannot waste it on someone who has no interest in working with us. We are very serious about our case management work and believe that to operate the shelter in any other way is to “warehouse” the homeless, which enables people to not get it together.

One of the first things the Headrest shelter coordinator does with a new lodging client is administer an M.A.S.T. (the Michigan Alcohol Screening Test) assessment to find out how important alcohol and other drugs have become in the person’s life. If we determine that an addiction is present, or that the person has an unhealthy preoccupation with drinking or drugging, we have another set of rules designed to give our lodgers support for breaking the bonds of addiction. Addicted lodgers who are safe from medical detox problems may stay with us if they attend an Alcoholics Anonymous meeting every day and meet with Headrest substance abuse counselors several times a week.

In the case of more severely addicted persons, Headrest counselors explain the benefits of entering a twenty-eight-day treatment program at a New Hampshire Office of Alcohol and Drug Abuse Prevention-supported treatment center, then help make the arrangements for the client to enter a program. The complication is that it can take two months for state-funded beds to become available at inpatient treatment centers, so we have to make sure Headrest is a safe place for recovering people to stay while waiting for a bed — an interesting challenge for an agency that is physically only a hundred yards from a New Hampshire State liquor store.

The simple fact of life for Headrest is that we have seen too many people fail at recovering from becoming homeless because they were not able to stop drinking or drugging. If we do not help an addicted homeless client learn to become and stay sober and drug free, we know that this person will never really escape from the hole he or she is in. Relapse is so common that it is almost expected if the addicted person does not also learn how to get ongoing support for making healthy choices. It means that our shelter people see the addicted person trying to come back for another chance over and over until he or she gets serious about fighting the problem.

Other aspects of the case management we are able to do in our small shelter include acquiring modern job skills, finding appropriate jobs and learning how to apply successfully for the jobs, arranging budget counseling, finding affordable housing and dealing with the landlords, accumulating security deposit funds, and working out those constant transportation issues to make it possible to get to the job location.

The following two cases illustrate how successful Headrest’s case management efforts can be.

Hank

An Enfield church called Headrest's twenty-four-hour hotline looking for help housing "Hank", a seventeen-year old "throwaway" youth. Denied services by the New Hampshire Division of Children and Youth Services, Hank, who had been in and out of group homes for ten years, was homeless. Headrest sheltered Hank for five weeks while he looked for a job. Headrest's shelter coordinator arranged for him to take classes to gain his GED and helped him develop job-hunting skills. While at Headrest, Hank also received support and positive feedback from teens working on Headrest's Teenline. This peer support helped reduce his feelings of alienation and fear.

Hank is still working full time, and has made the transition to living on his own. He has earned his GED and hopes to save enough money to take college-level business and accounting courses.

Sam

"Sam" was alcoholic and homeless. Fired from his job for an alcohol-related incident, he finally realized he needed help and called Headrest's twenty-four-hour hotline, looking to get help for his drinking and drugging. Headrest provided shelter and food to Sam during his first days of sobriety in fourteen years!

Headrest's substance-abuse counselors helped Sam decide that he needed inpatient treatment for his addiction. Headrest arranged a bed in a state-run treatment facility. During the forty-five-day wait for a treatment bed to become available, Headrest provided the necessary security, stability, and support for Sam to treat his disease and make positive changes in his life. He went to AA meetings every day, met with Headrest counselors, and attended therapy groups for his substance abuse.

After treatment, Sam again found himself without a place to stay. He contacted Headrest immediately, and was again offered shelter. During his second stay he continued to treat his alcoholism, got a job, and moved into an apartment with another recovering substance abuser he met at Headrest. Sam is still sober, working, and able to take care of his own well-being. He is returning the good service Headrest provided him by driving new Headrest clients to AA meetings, and often dropping in to give support to current shelter guests.

Headrest is able to accommodate only between five and eight lodgers at one time. We are expanding the shelter in order to add another five beds in late winter or spring of 1992. Even then we will be small enough to insist on carrying out the demands of our case management technique with our homeless clients. Clearly, large urban shelters that have many dozens more beds and homeless people to just feed and keep safe overnight could not have the staff or resources to work so closely with lodgers to resolve the issues that made them homeless. Big-city shelters are about keeping people alive, whereas small-town shelters like Headrest are about empowering people to take charge of their lives — or should be!

Being small, Headrest annually turns away nearly one person for every one we are able to take in. Some of the people who do not stay with us are unwilling to accept our lodging rules and the need to confront their addictions and other problems. Lately, a lack of space has been the most frequent reason someone who requested lodging was not able to stay with us. The New Hampshire economy has had a direct

effect on our ability to serve people in need by making it so much harder for us to move clients through successfully and get them back on their feet. Jobs simply are not available in our area the way they were in the past. Competition for the few jobs that do become available is always fierce.

This is a particularly hard time for our lower functioning clients, people whose IQs are low, but not low enough to qualify them for Supplemental Security Income. Like every area, the Upper Valley's workplace historically has included a certain number of jobs people of lower intelligence would have done, from washing dishes overnight at the local truck stop to mopping floors at nursing homes. In this highly restrictive job market, those jobs go to considerably higher functioning people than previously, thus blocking out those at the lower end of the job skills and intelligence scales.

Despite all the problems the New Hampshire socioeconomic-political culture throws at us, we still have success stories like Hank and Sam, and we still believe our case management advantage is worthwhile. We have learned to be more austere in our approach to budgeting our scarce shelter resources because we believe our mission calls for us to serve disadvantaged and addicted people by empowering them.

Another big advantage we have created for ourselves in our rural surroundings is one that comes from being able to work so very effectively with our sister agencies and community groups. We clearly recognize that the problem of homelessness is too big and too complex for a single small agency to have an appreciable impact on it.

In August 1991, Headrest was named the 526th national Daily Point of Light by the White House. We were the fourth point of light so designated in New Hampshire, and the first in the Upper Valley. The purpose of the designation is to recognize and honor people and groups that have taken leadership roles in combating problems in the community, and to promote volunteerism. Headrest was considered worthy of this honor because we have been heavily dependent on volunteer help to get the job done, and we have always tried to encourage the joining of community resources as the way to approach complex problems.

The leadership role the thousand points of light criteria uses is illustrated by Headrest's involvement in many committees and coalitions that involve people combining forces to better the community's approach to the problems of the day. Headrest was instrumental in raising the alarm about rural homelessness that led to the formation of the Upper Valley Interfaith Coalition Against Homelessness; we play a major role with the statewide New Hampshire Coalition for the Homeless; and we continue to work hard with our social service and medical community colleagues to make sure the Good Neighbor Medical Clinic will have a successful opening and fulfill its mission of making free basic medical care available to people who have inadequate or no health insurance.

When we talk about homelessness in the community, we make it an important point to mention the work our sister agencies do on this issue. We let people know that the work each of the other agencies is doing is absolutely vital to Headrest's efforts to help the homeless. Audiences are surprised to hear us say that we consider a financial or in-kind donation or volunteer commitment to the Haven, WISE, or LISTEN just as important to Headrest's ability to provide services as a donation to Headrest itself.

We really think this is true. Further, the ability of the human service community in the Upper Valley to respond to community needs has been improved significantly by

coalition building. Nowhere is this more true than with groups whose purpose is to provide services to the homeless or nearly homeless. In our area, the Upper Valley Interfaith Coalition Against Homelessness is a shining example, and its success has been matched by a group of human service agencies and health care professionals who are planning the opening of the Good Neighbor Medical Clinic. On a statewide basis, the New Hampshire Coalition for the Homeless, with whom Headrest and LISTEN regularly participate, has been a unifying force for agencies that provide shelter and basic services to people in need. The New Hampshire Coalition also benefits from participation of state agency personnel who are involved with homeless issues.

Because complex social issues like homelessness are not solvable by agencies and individuals working alone, we believe there is power to be realized from networking and forming coalitions to coordinate services and advocacy efforts. The benefits can be wide ranging.

- We can coordinate our programs more successfully — federal, state, foundation, and community funding often rightfully require coordination of services to avoid duplication and improve the quality of services. In the Upper Valley, services offered by Headrest, LISTEN, WISE, the Haven, Habitat for Humanity, and Twin Pines Housing Trust complement one another without overlap, so that all can be actively promoted by the Upper Valley Interfaith Coalition Against Homelessness.
- Service providers can share information on what works and what doesn't in their programs, increasing the potential for successful case management with homeless and disadvantaged clients. As an example, the New Hampshire Coalition offers monthly statewide training programs on issues of importance to service providers to enhance each agency's potential. In September, Headrest put on a full-day training program on alcohol and other drug-abuse issues affecting homeless shelters for the statewide meeting.
- Collecting and sharing data are useful for lobbying government officials and making the public aware of developments. The New Hampshire Coalition has been able to let the state know that the trend in shelters is for homeless people to stay longer, so we are able to serve fewer individuals overall. We know that the reason for this is found in nearly all parts of the state: the tight job market has made it so much harder for our clients to find work and get started on the business of learning to support themselves once again.
- Broad representation — the Good Neighbor Medical Clinic steering committee, for instance, includes doctors, nurses, nurse practitioners, and administrators from both of our major area hospitals, plus private practitioners and several directors of social service agencies. The breadth of involvement in this coalition has already resulted in funding commitments from both hospitals and enthusiastic support from government officials in both Vermont and New Hampshire.

The story of Headrest's participation in the formation of the Upper Valley Inter-faith Coalition Against Homelessness is interesting, because it demonstrates the potential of efforts to organize on the community level. In 1988, Headrest received a small grant from the Lou and Lutz Smith Foundation, administered by the New Hampshire Charitable Fund, for the purpose of putting together a publicity campaign that would make our services more accessible to the public. The primary focus was to be making people more aware of our crisis intervention, information and referral, substance-abuse counseling, and emergency shelter availability.

A portion of the grant was used to create a brochure specifically about the incidence of rural homelessness in the Upper Valley. We persuaded two of our sister agencies, WISE and the Haven, to let us highlight their shelter programs as well as our own in the brochure. The attractive flyer we created caught people's attention with a cover page that read: "Homelessness. If you think it's only a big city problem, Think again . . ." The information that followed used lodging statistics from all three agencies and created a convincing picture of homelessness in our area. It also suggested many ways in which concerned citizens could respond to help the three agencies in their missions of helping the homeless.

After we had circulated the brochure in the community and in area churches for several months, in July 1989 a Headrest board member used it as an entry to arrange for a small group to speak at a monthly meeting of the area's Ecumenical Council of Churches. At that pivotal gathering, Paul Feeney of the Haven, a lay preacher, together with Donlon Wade and Gregory Norman of Headrest, spent an emotional evening enlightening the representatives of fifteen churches in attendance about the growing problem of homelessness in our area. The council was asked to find ways to help out, especially since Headrest was turning people away from its five-bed shelter nightly. It was especially effective to have Paul Feeney deliver his opinion that the first priority for improving the area's ability to fight homelessness ought to be expanding the Headrest shelter.

From our perspective, what followed that meeting was fairly miraculous. Several of the participants, led by Dr. Paul Manganiello, continued to discuss the question of how they might have an effect on the problem. Dr. Manganiello managed to get at least one person to be a representative for each of a dozen churches that came together that September for an organizational meeting of a coalition to fight homelessness in the Upper Valley. The first few monthly meetings were spent raising consciousness about homelessness in general and issues the shelters were facing, and discussing all the ways such a coalition could possibly help.

The group agreed that expanding Headrest's shelter capacity would be the most ideal thing that could happen in the community, since the services Headrest offers homeless individuals are the most effective way to make an impact. However, since Headrest had only rough building plans at the time and no capital campaign under way, the group searched for an interim plan, something that would make it more immediately possible for Headrest to take in more people and turn away fewer people in need.

While most of the participants in the discussion group were lay people, a concept voiced by one of the Protestant pastors present began to catch on, specifically, "Why don't we concentrate on ways to use God's churches to do God's work?" With that

in mind, a plan had taken shape by January 1990. The group, organized as the Upper Valley Interfaith Coalition Against Homelessness, set about lining up area churches to provide bed space in rotation for the overflow of lodgers from Headrest's shelter. The coalition's representatives in each church continued to speak to the issue of homelessness whenever possible, as presentations during church services and in discussions with various groups within their churches. This consciousness-raising effort made it possible to recruit volunteers from among the several congregations to be overnight companions to the lodgers being sent from Headrest to the churches.

In March 1990, on Vermont Town Meeting Day, the coalition held a training for overnight volunteers at the Norwich, Vermont, Congregational Church. Those of us who had been involved with the coalition all along were stunned when seventy volunteers walked through the door and put their names on a list to be used for scheduling the overnights! We proceeded to train the volunteers in protocols the coalition had agreed to use, gave a few hints on active listening and how to converse with homeless people, and explained to the group how Headrest would handle its role.

Headrest's agreement has been to admit up to three homeless lodgers in excess of our bed space. Each night we designate one, two, or even three of the people in our shelter to spend the night at whatever church is on the rotation schedule for that week. One of the coalition's overnight volunteers comes to Headrest at 10:00 P.M. to pick up the lodgers who are going out to the church, take them there, and spend the night on beds or cots provided by the church supervising the lodgers. The clients are brought back to Headrest just before seven the next morning.

We now have eight churches in four communities participating in the program, so that each one is on the schedule for a week's time every eight weeks. We have had such a good response that the overnight volunteers are usually not asked to commit to more than one night each month. We try to use volunteers who belong to the church that is providing the beds that week, but it is not always possible to do so. Schedulers do try to make sure that one woman is paired up with one male volunteer to make it possible for Headrest to send lodgers of either or both sexes to the church.

Headrest's part of the bargain is to be very careful about whom we send. It's a rule that no lodgers are sent to the churches for overnights until they have been at Headrest for at least a couple of days, so that our shelter people get to know them. We do not send anyone who we think might cause problems for the overnight volunteers, or who might still be in an alcohol or drug crisis following detox. Some volunteer overnight companions are elderly men and women who generously give their time to help the homeless. We have dedicated ourselves to making sure that the program runs smoothly and does not result in any uncomfortable or dangerous situations for the volunteers. In fact, looking back at almost two years of this overnight program, the only incident we can recall hearing about was when two Headrest lodgers who were going out to the churches regularly figured out that they could convince some of the overnight companions that the volunteers were supposed to bring along a box of doughnuts for the overnight.

The benefits we have realized from the Upper Valley Interfaith Coalition Against Homelessness overnight companion program have been many. In addition to the obvious one of being able to take in more homeless lodgers at Headrest, there have been several pluses that were pleasant surprises along the way. We have been able to

get the attention and involvement of a significant group of middle- to upper-middle-class concerned citizens, mostly liberal in their orientation, for the problem of fighting homelessness in our area. With 150 to 200 such people from fifteen churches involved with the coalition, we have had a ready-made audience for funding appeals, for in-kind donations for the shelters, and a group that could help spread the word among the much wider circle of their church congregations.

Early in 1991, when it came time for Headrest to get its capital campaign to fund the shelter expansion off the ground, the coalition members were very active. They not only contributed substantial donations themselves and encouraged groups at their churches to hold fund-raising events to support the project, but a core group of five to six persons stepped forward and asked to be trained to go out to solicit money from potential large donors we had targeted. Their efforts turned out to be enormously important to an agency that had never conducted a capital campaign, and, in fact, lacked sophistication in doing one alongside its general annual fund drive. In late 1991, construction was well under way at Headrest, and we expected to have twice as many beds available for homeless lodgers by midwinter.

The Upper Valley Interfaith Coalition Against Homelessness continues to meet monthly. The group includes a publicity committee that puts out a quarterly newsletter to be distributed at all the churches in the area. In it, activities, issues, and projects involving all Upper Valley agencies that work on alleviating homelessness and increasing affordable housing are highlighted. The fall 1991 issue, for instance, carried a banner headline, "Eight Ways to Help the Homeless," and identified eight projects that either needed contributions, in-kind donations, or special volunteer support. Another committee is studying transitional housing issues with the idea of identifying the next project for the coalition to take on once Headrest's building expansion is completed.

Agency heads and coalition members have become better known in the community as we have all done our part to help get the word out about fighting rural homelessness. This has led to many of us being asked to give talks and interviews and be on panels about homeless issues. One of the most pivotal of these occurred in November 1990, when the League of Women Voters held a public forum in Hanover, New Hampshire to discuss homelessness. Before a packed house of five hundred citizens, a panel of "experts" that included Headrest, the Haven, and LISTEN directors and representatives from the coalition answered questions for over two hours.

When a member of the audience asked what sort of medical assistance was available for homeless people in the Upper Valley, a coalition and Headrest board member, Sandra Zubkoff, who is a nurse practitioner, stood up and challenged the area's medical community. She stated that the Upper Valley, which includes two of the best-known hospitals in northern New England, had only one doctor who was willing to see homeless persons. The very next night, Dr. Paul Manganiello took that message to a meeting of the Grafton County Medical Association, which passed a unanimous resolution supporting an action plan for making medical care accessible to people who lack insurance and resources to afford adequate medical care.

Since then, a spin-off group from the Upper Valley Interfaith Coalition Against Homelessness, including social service agency people, church representatives, plus doctors, nurses, and nurse practitioners from the Dartmouth-Hitchcock Medical Center and Alice Peck Day Hospital have been meeting to plan the establishment of a free medical clinic. It materialized in January 1992, with the opening of the Good

Neighbor Health Clinic in space provided by Saint Paul's Episcopal Church in White River Junction, Vermont.

We started with the premise that because our work with the rural homeless involved a smaller population than that served by larger shelters in urban areas, we could not expect to have the same access to state and federal funding sources. However, being small has some distinct advantages in the quality of our case management with shelter clients. Also, being able to work effectively to organize community support has, in Headrest's case, been an interesting compensation for our rural setting.

Within the shelter, Headrest's shelter coordinator and substance-abuse counselors are able to accomplish their work with homeless lodgers in a way that is the envy of shelter providers in more heavily populated areas. Treating homeless people with dignity and respect is certainly part of this. It is only because we care so much about the people who come to us for help that we are able to make sure we are really contributing to their recovery, whether it's about their economic well-being, emotional outlook, or breaking free of a dependence on alcohol or other addictive drugs.

It is Headrest's success stories from working with our homeless clients that has created the climate for our successful networking in the community. The Upper Valley Interfaith Coalition Against Homelessness and its members have contributed financially and with many hundreds of volunteer hours specifically because they have looked closely at the quality of Headrest's case management with the homeless, and determined for themselves that this represents a realistic way of helping the homeless that they are inclined to support.

The problem of homelessness, whether urban or rural, is really far too complex for one organization to have an impact, even in a small area, acting alone and in a vacuum. We recognize that each agency and group has input to give and an important role to play if we are serious about helping people in need. It seems rather ironic that in the midst of the world's most advanced capitalistic society, right here in northern New England, the answer that has worked best for us is cooperative effort and a repudiation of competition among social service providers. ♪

Notes

1. "The New Hampshire Emergency Shelter Commission statistical report of Emergency Shelter Use in New Hampshire, FY 90 vs FY 91."
2. Jeff Feingold, "Henrietta Charest: Advocate for New Hampshire's Homeless," *The Spectator*, April 1991, 23.
3. Peter Marin, "The Prejudice Against Men," *The Nation*, July 8, 1991, 48.
4. Ibid.
5. Ibid.
6. Ibid., 51.
7. Peter Anderson, "The Rural Poor," *Boston Globe Magazine*, September 16, 1990, 34.

In Search of Safety

Double Jeopardy for Battered Women

*Pamela H. Zappardino, Ph.D.
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Battering is the single most common cause of injury to U.S. women. Its myriad consequences affect every aspect of the lives of its victims and its children. In their search for safety, many battered women and their children find themselves homeless not because they do not have homes, but because their homes are unsafe. They are homeless because to go home would invite further injury or even death. This article discusses the unique issues and implications of double jeopardy for battered women, including the crisis components of their homelessness, the economic and emotional impacts, the child custody issues, the inadequacy of the homeless shelter system to deal with their special needs, and the sexism and social milieu that continue to downplay the seriousness of the problem. The authors offer suggestions for confronting the jeopardy through strengthening the network of battered women's shelters and programs, providing a specific array of supportive services, changing the legal approach to domestic violence, and radically altering public attitudes toward battering that lead to shifting the responsibility for solving this problem from the battered women's network to the community at large, where it originates.

Joan is a writer; Carol has been home caring for her three small children; Kathy is an administrative assistant in a large firm; Barbara is an executive in the finance industry; Mary has been on welfare for several years. These women all have something in common — they are all homeless for the same reason. They are homeless because their homes are unsafe, because going home means injury and possibly death. They are all battered women.

All the names in this article have been changed for several reasons, chief among which is that battered women are in constant danger even after they leave their violent home situations. Any risk of identification can be life threatening. Battered women also face stigmatization because they are victims of a crime our society has trouble facing. Anonymity is their only assurance of being able to tell their stories safely.

Pamela H. Zappardino, for ten years executive director of Sojourner House in Rhode Island, is a consultant on management and organizational issues to the nonprofit community. Deborah B. DeBare is executive director of the Women's Resource Center of South County, a shelter program for Rhode Island victims of domestic violence.

Battering is the single most common cause of injury to women in the United States, affecting 6 million a year according to *Time* magazine. In the time it takes to read this paragraph, the FBI tells us, another woman will be beaten by her partner — it happens once every fifteen seconds. Researchers estimate that violence occurs in 30 percent to 60 percent of all intimate relationships.¹ Translated into everyday reality, these statistics paint a frightening picture — domestic violence is everywhere. Far from being an unusual occurrence, it is commonplace, respecting no boundaries, no demographics. Women are beaten by husbands, ex-husbands, boyfriends, and female lovers. It happens in every city and town, in every neighborhood. It happens to someone we all know.

In Rhode Island, a state with a population of nearly one million people, more than ten thousand persons received help from battered women's shelter programs in 1990. Domestic violence, however, is an issue that has been kept behind closed doors for the most part. Considered a family matter, intimate violence was long considered an acceptable component of a domestic relationship. In fact, throughout Western history, legal systems have not only permitted, but prescribed conditions under which a husband should physically "discipline" his wife. The phrase "rule of thumb" comes from English common law, which allowed a man to beat his wife as long as he used an instrument no greater in circumference than his thumb. Such laws persisted into this century.

Privatization of what between strangers would have been considered criminal behavior has created a system ill equipped to deal with the consequences of such violent behavior, and communities ill prepared to confront the issue head-on. Only recently have our law enforcement officials been willing to proclaim that domestic violence is and should be treated as a crime. Only recently have we as neighbors, friends, and relatives been willing to believe that such violence exists around us.

But even with these shades of change, the situation is grim. Julia tells of her family's reaction to her situation. "They asked me what I did to make him hit me," she says. "I don't know what I did; he just hit me." We are still unwilling to believe that a woman doesn't somehow cause the violence. And we have told this to women for so long that they have a hard time believing they are not to blame for their abuse.

In pronouncing a lenient sentence on a longtime abusive husband who had killed his wife by shooting her in the face, a midwestern judge stated that, in his view, the woman had contributed to her own death by filing divorce papers. In Rhode Island, which has among the most progressive domestic abuse statutes in the country, women must swear that they were abused with "no provocation" on their part in order to obtain restraining orders against their violent partners.

This tendency to blame the victim places a heavy burden on battered women. Our society already places much of the responsibility for a successful relationship on women. We teach our daughters that it is up to them to say no when they are out on a date. It is up to them to determine "how far things go." At the same time, we often absolve our sons from any of that kind of responsibility. "Boys will go for what they can get," we say with resignation. The message is all too clear. What happens to a woman in a relationship is her fault. She should be able to prevent bad situations since men can't be expected to control themselves. This attitude is demeaning and dangerous not only to women, but to men as well.

Added to this dynamic is the emotional basis of intimate relationships. As Julia explains, "I love him. I don't want him to go away, I just want him to stop hitting me!" It is very hard to believe that someone you love wants to hurt you. The tendency to forgive, to believe an episode of violence is an isolated incident, is strong even in the light of contrary evidence. And as Sylvia adds, "You don't want anyone to know about it. You're ashamed, like you did something wrong. And besides, you don't want people to not like him. Because when things get better, you want people to still be okay with him."

A nine-month-pregnant staff member at Sojourner House, a shelter for battered women in Rhode Island, was talking with a high school class about domestic violence. A student asked what she would do if she went home that night and her husband beat her up. The question left her struggling for an answer. Returning to the office, she was still struggling. "I wanted to say I wouldn't put up with it, that I would leave immediately. But I couldn't. We've been together a long time and I'm about to have a baby and I love him. I would want to believe it would never happen again. I don't know what I'd do."

It is not an easy question to answer, and our expectation that women whose energy is devoted to survival for themselves and their children will be able to answer it quickly and easily is unreasonable. The level of danger in domestic violence situations and the concomitant fear it produces are often overlooked by the general community and the service providers outside the battered women's network.

FBI statistics indicate that, every twenty-two days, a woman is killed by her abusive husband or boyfriend, many times after having obtained a restraining order barring the abuser from approaching her. Three thousand women are killed each year as a result of domestic violence. Thousands more visit emergency rooms and doctors' offices for serious injuries every year. Many have been told by their abusers that should they dare try to leave them, they will track them down and kill them or perhaps harm the children. The women who live with these men know what they are capable of, and newspapers tell them weekly that such threats are often carried out.

Under such circumstances, the concept of home as a place where one is safe is shattered. Home is a prison, a place that becomes more dangerous than anywhere else. This reality, perhaps more than any other, distinguishes battered women and their children from other homeless families and makes resolution of their situations even more complex. The issue is not one of finding a home, it is one of finding a home that offers safety. The fear of being found and harmed keeps many battered women on the move. It keeps many of them homeless. The harshness of this state of affairs is difficult to comprehend, but it is very real. It underlies every action, every solution that battered women undertake.

These women and their children are not in jeopardy merely because they are homeless but because, for many of them, someone is actively looking for them, someone who is likely to escalate the level of violence when he finds them, who will threaten and intimidate them at best and take their lives at worst. This is the context in which battered women and their children find themselves without a home. The issues it raises are myriad, and in searching for a solution to the problem, its implications must be addressed.

Homeless Battered Women: Unique Issues and Implications

Within the context detailed above, the difficulties faced by homeless battered women and their children come into clearer focus. In addition to their primary need to be safe from further violence, the immediate crisis component of leaving a violent home, the double stigma of being battered and homeless, the child custody issues that inevitably arise, and the sexism within the homeless shelter systems all contribute to the unique challenges faced by homeless victims of domestic violence.

Battered women rarely address the concept of homelessness until an acute episode of violence or abuse has resulted in the "straw that broke the camel's back," as many women explain it. Since, as noted above, many women believe that each abusive incident is a single episode — one which won't happen again — they rarely formulate a plan of action that includes abandoning their home. It is rare for a woman, like the character in the movie *Sleeping with the Enemy*, to carefully plan an escape and prepare herself emotionally for a potential impact.

A battered woman who has left her home without having planned to do so is usually confronted with the problem of identifying herself as homeless for the first time. Unlike a family or individual who may know that an eviction notice is imminent or a person whose substance abuse or difficult behavior has led to cohabitants taking progressively more drastic action, culminating in forcing him or her from the residence, the battered woman has generally never anticipated homelessness.

Such a crisis situation is compounded by the trauma of the violence from which the woman has escaped. Many battered women need time to gather their thoughts once they leave their homes, because they hadn't planned their next step. Where they go and what they find there will play a critical part in their working through of the situation.

"I didn't have any idea where to go," said Carol. "I packed a garbage bag full of clothes for my kids, grabbed the car keys, and left the house without thinking what I'd do next." When Carol arrived at the Women's Resource Center of South County, a Rhode Island shelter program, she told the staff, "I never thought I would have to leave my own home."

The place a battered woman goes, whether it is a shelter, a relative's house, or some other location, must first provide her with safety from the abuser. It must also offer a supportive environment for the woman so that she can assess her situation, consider her options, and gather strength to begin making choices and setting goals for her life. The environment, and the people around her, must be sensitive to the double crisis she is experiencing: the violent danger she has fled and the fact of being homeless for what is probably the first time.

Another issue with which a battered woman must deal in coping with the psychological impact of the life-and-death nature of her escape is not only having to leave her home to find safety, but forfeiting that home to the person who caused her danger in the first place. The violation she feels, knowing her abuser is still living in her home, adds further trauma. Despite the grim situation in which she finds herself, a battered woman may also find it difficult to identify her family as homeless. She may not feel "homeless," because in some cases she may feel that her current circumstance is simply a temporary displacement from her home. She may anticipate returning to her home if she is able to retain child custody or to obtain a temporary restraining order, or if her abuser is convicted.

Most battered women live in a world of denial for many months or even years, believing that the abuse will go away, or that the abuser will change. Denial can become the easiest way for them to deal with the concept of being homeless, a coping mechanism that often prevents them from dealing with issues of homelessness. Many battered women introduce themselves, as Kathy did, by saying, "I am not really a battered woman, it's just that my husband [boyfriend, lover] hits me." In the same way, many displaced battered women introduce themselves with: "I'm not really homeless, it's just that I left my home."

Child custody issues inevitably complicate the situation for a battered woman who has left her home. If she takes the children with her, she can be challenged in court for placing them in an "unstable environment," that is, a shelter. If, for safety reasons, she decides to leave the children with her parents or a friend, she could be attacked in court for abandoning them. If she leaves them with the abuser, she could jeopardize their safety — and be charged with abandonment as well. In searching for the best solution, some women take drastic steps. One well-publicized Rhode Island case involving domestic violence concerned a battered woman who fled, "kidnapping" her children from the abuser-father to protect herself and them. Risking criminal charges, she was driven by an overriding need for safety, for freedom from danger for herself and her children. Her thoughts of what homelessness or underground living might involve were secondary to her desire for a safe haven.

Once battered women have fled their violent homes, the sexism they face in the homeless shelter system is no different from that in the culture at large. It does, however, have an impact on their experience of homelessness and makes their struggle toward independence more difficult than that of a male's within the same system. Most notably, the majority of homeless shelters are not equipped to handle infants or children. A woman who has two or three children is often asked to split them up or have male children sleep in a different area from the females. Most shelters are unable to provide child care, so if a woman needs to leave her children for an hour to obtain a restraining order, to keep a social services appointment, or to look for an apartment, she is forced to take all her children with her or make her own arrangements. In addition, many shelters do not have the capacity to take into account the nutritional requirements or medical needs of children or pregnant women.

Again, child care issues loom paramount when a woman attempts to find work to support herself and her children. A battered woman who has been out of the work force may find herself eligible only for jobs that do not pay enough to cover day care costs. Even if she has been employed, these costs place a tremendous drain on her resources.

The development of affordable housing opportunities has disproportionately favored single men. Landlords often discriminate against women with children, because our culture views them as unstable or problematic families. In truth, a number of these "unstable" families are victims of domestic abuse seeking safety and stability on their own.

Many of these problems are obviated by women taking refuge in a battered women's shelter — if room is available. But even in making this choice, a woman must deal with another form of discrimination — homophobia. Some women are afraid to approach a battered women's shelter because they believe the rumors that such shelters are filled with lesbians and the stereotypes of what lesbians are like. These false fears are planted in their minds by a misogynistic culture, which puts

down women's initiatives toward self-reliance. A batterer, fearful that his partner will flee to a women's shelter, frequently threatens her by making such statements as, "If you think you'll be safe there, you should see what those lesbians will do to you." Society has done nothing to counter women's fears.

If a woman is being beaten in a lesbian relationship, homophobia also acts to keep her from seeking help. She may be afraid that she will not be accepted at a women's shelter — a "straight women's" organization, that if she is open about her lifestyle, she will lose her job, her family, and her children, and she may fear that no one will believe that she is being beaten by another woman.

Although the support for all victims of domestic violence has developed tremendously during the past fifteen years, largely through the efforts of the battered women's movement, this dramatic double jeopardy still faces homeless battered women. With the stigma, the sexism, and the crisis dynamic of escaping from a violent situation, it is remarkable that so many women are able to find the strength to leave their abusers and forge ahead on their own despite the dangers and the risk, or in the midst, of homelessness.

Confronting the Jeopardy: Taking Action

The existence of a network of battered women's shelter programs throughout the country is a testament to the efforts and accomplishments of advocates in developing essential services for victims of domestic violence. However, the presence of a roof over a woman's head and meals for her children does not address the cause of her homelessness nor does it provide a solution for preventing an ongoing cycle of victimization and homelessness for her and her children. Much work remains to be done to prevent women from having to leave their homes in search of safety.

The legal situation with regard to domestic violence varies greatly from state to state. In Rhode Island, there have been, on one hand, significant improvements in addressing domestic assault as a crime. On the other hand, there is still a need for continued improvement and change, both in statute and in attitude.

Prior to 1988, if a Rhode Island woman called the police to respond to a domestic assault, the police, on arriving, would be most likely to defuse the immediate crisis by walking the assailant around the block to "cool him down" and then ask the woman if she wished to press charges. Few women, in assessing the protections — or the lack thereof — available to her if she had her abuser arrested, did so. The police would then depart, leaving the woman to face an angry abuser and a situation that was likely to escalate.

In 1988, the Rhode Island legislature passed a statute referred to as the mandatory arrest law. Thirteen states now have similar legislation requiring an arrest with probable cause.² This law requires police officers to make an arrest when, in response to a domestic assault call, they have probable cause to suspect that an assault has occurred. The police officer, not the victim, makes the decision to arrest. As a result, women are more likely to receive immediate protection from the police at the time of an assault, and they are also reassured that the abuser will be removed from the home at that time. While he is likely to be held only a short time prior to being released on bail or his own recognizance, the victim is provided with an opportunity to plan her next action, whether to go to a shelter for safety, move in with family, or go to court to get a temporary restraining order against the abuser.

Although the legal system has become more responsive to the needs of battered women with the passage of this law, it is still not a panacea for the problems and threats they face. Women are still beaten, abused, and killed by their husbands, boyfriends, or lovers. Temporary restraining orders are regularly violated, and battered women often say they feel safer in a shelter than in their own homes. Early reviews of recidivism rates among batterers show that offenders are likely to be brought to court repeatedly for offenses against the same or other victims.

The battered woman's syndrome is still poorly understood by the community and the courts. A woman who doesn't leave her abuser is blamed for staying. We fail to recognize the terror with which battered women live daily, the constant level of energy that must go into keeping themselves and their children safe, and the paralysis that results from coping with these issues in the face of no external support and the knowledge that safety is unattainable no matter what steps they take. We understand this behavior when it is displayed by hostages. What we must recognize is that battered women are no less hostages in their own homes than those more publicized individuals.

In the same way, the magnitude of the problem of domestic violence remains to be acknowledged by society at large. The United States lost 39,000 soldiers in the Vietnam War between 1967 and 1973. During that time, 17,500 American women and children were killed by members of their own families. In the United States, a woman is more likely to be assaulted, injured, raped, or killed by a male partner than by any other type of assailant.³ Yet the true nature and scope of domestic violence remains obfuscated by national policymakers. The only real solution to the problems of homelessness, disenfranchisement, and victimization experienced by battered women rests in a national shift in our culture's attitude toward them, which must take place in every community, in every individual.

This will involve acknowledging the problem's magnitude, allocating adequate national resources to address the problem, and establishing cultural norms that do not accept violence in interpersonal relationships. It will also involve acknowledging that nothing deserves a beating. One person can do nothing to cause another to be violent toward her or him. It involves placing the blame for the violence where it belongs — with the abuser.

Attempts to develop intervention strategies, prevention programs, and support services have proved effective in making progress on these issues. With adequate resources, shelter programs will be able to address the victims' immediate problem of homelessness and jeopardized safety, and provide prevention and intervention services to reduce the risk of future victimization. Crisis hotlines, group support services, psychoeducational programs, advocacy and case management services, as well as shelter services, remain underfunded in each of the battered women's shelter programs in Rhode Island as well as throughout the country.

While there is no simple short-term solution to make the problem of domestic violence and the homelessness that accompanies it disappear, researchers, front-line staff, and battered women agree that the critical step is ensuring that these women have access to necessary services and resources. Cris Sullivan concluded that battered women need assistance in the following areas: obtaining material goods and services, education, transportation, finances, legal assistance, health care, social support, housing, employment, and children's issues, including child care.⁴ To prevent the cycle of violence, homelessness, and victimization for abused women, advocacy

programs focusing on accessing available resources need to be expanded. Crisis hot-lines need to continue to provide a confidential support for women. Shelters must continue to provide support services as part of a basic shelter stay.

In closing, we must, even at the risk of redundancy, return to the larger picture. Shelter programs can do a lot, but they can't do it all. Instead of shifting the burden of solving the problems posed by domestic violence onto the shelter programs, society as a whole must take responsibility for accepting the violent and abusive behaviors that created the problem in the first place. As Mary, a shelter resident, told the other women in her shelter, "It's time for the world to wake up to what's really happening, read the writing on the wall, and see the damage that's been done before it's too late."

Still, every fifteen seconds, in every community, in every neighborhood, a woman is beaten! 🚬

Notes

1. K. Daniel O'Leary and Ileana Arias, "Assessing Agreement of Reports of Spouse Abuse," *Family Abuse and Its Consequences*, edited by Gerald Hotaling et al. (Newbury Park, Calif.: Sage Publications, 1988), 218-41.
2. Rhode Island Coalitions Against Domestic Violence, from the National Center for Women and Family Law (New York, 1991). The thirteen states with mandatory arrest legislation include Delaware, Maine, Connecticut, Washington, Massachusetts, Minnesota, Nevada, Oregon, Utah, Virginia, Wisconsin, New Jersey, and Rhode Island.
3. National Woman Abuse Prevention Project, "Understanding Domestic Violence: Fact Sheets" (Washington, D.C.: National Woman Abuse Prevention Project, 1990).
4. Cris Sullivan, "The Provision of Advocacy Services to Women Leaving Abusive Partners," *Journal of Interpersonal Violence* 6, no. 1 (March 1991): 41-54.

The Pendulum Swings

The Effect of Changes in Policy on Homeless People with Mental Illness in Ohio

Kim Bryant, M.S.W., L.I.S.W.

Public policy in the problem areas of homelessness and mental illness has been reactive, rather than proactive, for the past thirty to forty years. As a result of this approach, federal and state policies have swung, like a pendulum, from one extreme to the other, taking the homeless mentally ill population on a most difficult ride. Public policies concerning these issues must become proactive, even if it means a complete overhauling of federal and state social service systems. Only with proactive policies will mentally ill individuals, and all people, have the housing, food, and health care they need, and the dignity to which they are entitled.

For the past five decades, federal and state policies on housing and persons with mental illness have swung from one extreme to the other, in attempts to alleviate the problems of mental illness and lack of affordable housing. These drastic changes in public policy have profoundly affected the homeless population who are also mentally ill. Over-the-Rhine, the poorest, most depressed area in Cincinnati, Ohio, is where Tender Mercies, Over-the-Rhine Housing Network, and the office of the Greater Cincinnati Coalition for the Homeless are located; it is where I most clearly see the struggles that the poorest of poor, the homeless, must face.

Tender Mercies, Inc., is a nonprofit organization providing permanent and transitional housing for people who are homeless and suffering from mental illness. The agency began in 1985, when three Catholic priests who lived in the neighborhood helped two homeless mentally ill women find apartments in the same building. When, shortly afterward, one was raped and murdered and the other assaulted, the priests decided to do something. They approached the owner of the building and asked to manage it at no cost to the owner; they would guarantee 100 percent occupancy and rent payments as long as the owner agreed to let them choose the residents. The owner agreed, and Tender Mercies was born.

Tender Mercies now owns and/or manages seven buildings, with a total of 128 units of housing, in Over-the-Rhine. The agency provides social services, a recre-

Kim Bryant, former executive director, Tender Mercies, is treasurer, board of the Over-the-Rhine Housing Network, and a member of the coordinating committee, Greater Cincinnati Coalition for the Homeless.

ation center, and other mental health services. Tender Mercies received no support from any mental health funder until 1988. Much of the original funding came from local corporations and private donations. Today, Tender Mercies funding comes in small percentages from the city of Cincinnati and United Way. Donations, rents, foundation grants, and purchase of service agreements with the Hamilton County Mental Health Board make up the rest.

To fill the gaps created by the swinging pendulum in federal and state policies, Tender Mercies has developed a spectrum of services. One is a transitional housing program offering a full range of support services, including on-site psychiatric and case management services, as well as twenty-four-hour staffing to provide safety, companionship, and a sense of security. The funding for this program came primarily from the Robert Wood Johnson Foundation with a small grant through the McKinney Act and some moneys through the state of Ohio. Ironically, after assisting in the setup of this program, the state of Ohio informed us it would no longer support transitional housing or any housing with services attached. These services frequently provide the support needed for clients to accomplish their individual aims.

One of the clients who was able to use the transitional housing service to achieve her goals was Brenda, who came into my office at Tender Mercies. The lobby staff had not recognized her when she came to let me know that "miracles do happen." Remarried and again employed as a licensed practical nurse, she is planning to return to school for her certificate as a registered nurse.

I remember when she showed up on our doorstep several years ago, while I was the director of our transitional housing program. She had been sent by the shelter down the street, a mass shelter serving mostly men and certainly not equipped to handle her issues. Brenda was wearing a fur coat (it was August); she had dirty stringy brown hair and grit ground into the creases and pores of her face and hands. The dark blue circles under her eyes seemed to hang down to her knees, but maybe that was because she was stooped so low that she looked as if she might fall over. She said she needed a place to stay. We told her to come in and we would try to figure something out.

She moved in with the clothes on her back and began to look after me. Our relationship grew. She let me know she had been a nurse and that I really needed to take care of myself; she could "see it in my eyes." I would agree, then ask her how she was taking care of herself. For months she watched me, advising me on my health, among many other things. At the same time, she refused medication and didn't reveal much; through hospital records we knew she had been diagnosed as having bipolar affective disorder.

People with this disorder are often manic-depressive, that is, they swing in mood from extremely depressed to extremely active. People with the most severe cases do not function well in their day-to-day lives when they are in the depressed state; in the manic state they seem to be able to accomplish impossible tasks with ease. Many people whose symptoms are under control or who do not have severe symptoms do very well. Some individuals with the more severe symptoms also have psychotic-like symptoms accompanied by hallucinations.

We didn't know how difficult it had been for Brenda until one day we found her in the hallway, huddled in a small ball, as small as she could make herself, screaming. She said that we were under attack; machine guns and bombs were falling

around her and she knew she was going to die. We all made it through that first attack, but there were more to come.

At one point she almost had me convinced of a petroleum spill. She came into the office, after standing around outside, to tell another staff person and me about the petroleum that had fallen on her — “Just a little, you see.” We began to get suspicious as we asked her to describe what happened. When she began a complicated story about the redness of the sky and the streaks of the petroleum coming from something concerning astronomy, we felt fairly sure that it was not within our reality. Brenda was a very bright and compassionate person. There were more than a few times when the staff and I really had to mull over whether our reality was in question, or hers.

Eventually, through all of this, Brenda began taking medication that eliminated the hallucinations and helped to level the mood swings, and she began to make plans for leaving. Hearing that we were making a public service announcement for television, she asked to be a part of it. She wanted to “give back some.” I sent the cameras to her room while I remained in the hallway.

Brenda related the beginning of her journey to our door, which she had never told us. She talked about working as a nurse, her large home, and her corporate lawyer husband. Then she became ill and was hospitalized. On her return home while her husband was at work, she found something wrong with the lock on her door, because her key wouldn’t open it. She went to a neighbor’s house and called her husband. His reply was “Honey, you don’t live there anymore.”

Locked out of her home with nothing but what she had taken from the hospital, and no follow-up from the hospital, she began the “shelter shuffle,” going from shelter to shelter trying to access housing and help. Along the way she lost her dignity and her delicate grasp on reality, until she arrived at our door.

Brenda’s story is and is not typical. Many people walk the same paths and face similar obstacles, yet each one’s story is different and unique. In her life the pendulum swung from one extreme to the other, but Brenda was able to hang on. That is what is not typical. Many people like Brenda lose their grip while waiting for the pendulum to swing.

How have our national policies and practices affected those who are unable to hold on? When talking about the “homeless problem,” most people quote numbers, ranging nationally from 250,000 to 3 million people. There is constant argument over the numbers to the detriment of the people whose stories are forgotten. Housing and service dollars are siphoned off to count people without homes rather than providing homes and services. Why can we not simply agree that there are too many people without homes and then get on with the task of providing needed services?

The 1980s represented a decade of despair and hopelessness for poor people and one of hope and financial gain for the rich. The extremes became more extreme and the middle shrank. The poorest 20 percent of Americans receive less than 5 percent of the nation’s income, while the richest 20 percent receive more than 40 percent.¹ Ronald Reagan’s trickle-down theory and practices did not mean that resources would trickle down but that more people would trickle down to the poorest extreme.

During the eighties an estimated 400,000 families were cut from Aid to Families with Dependent Children and food stamp benefits were reduced or eliminated for about one million people.² The federal budget financed 200,000 new and rehabilitated low-income housing units a year in the 1970s, but only 27,000 per year by 1986.³

Complicating this picture of available low-income housing is the fact that many units put into operation in the 1960s went out of service in the 1980s and that many of the units financed in the 1970s will be going off line in the 1990s. The loss of these units is a direct result of using low-income housing subsidies to subsidize for-profit developers. The provisions in the subsidies by the federal government allowed developers to turn the units to market-rate housing after twenty years of operation. Unless the federal government replaces those units going off line, there will continue to be loss of affordable housing and an increase in the number of poor and of homeless. Changes in these policies over the last decade can be held directly responsible for a large portion of the blame for the increasing homeless population.

The changes in state and federal mental health policies comprise another important factor contributing to the increasing homeless population. The swings of the pendulum in this area have resulted in many mentally ill people joining the ranks of the homeless. The percentage of persons with mental illness among the homeless population has been estimated from as high as 56 percent in some cities to 25 percent in others.⁴

In my opinion, changes in policy that reflect changing assumptions about appropriate interventions, amplified by cultural shifts and attitudes toward institutionalization, as well as statutory changes and interpretations, have resulted in an ever increasing population of people who are homeless and mentally ill. In reviewing the histories of institutionalization, the practice of treating mental illness, and the treatment of the poor in this country, as well as my experiences in working with systems charged with the responsibilities of doling out what meager resources are made available to them, it has become obvious to me that drastic and far-reaching changes must be made. The individuals whose stories appear in this article are examples of only a very small portion of the true injustices, pain, and sorrow so many must face in their day-to-day struggles to survive.

Jean Isaac and Virginia Armat give the following historical context for understanding the changes in the treatment of mentally ill persons, by both psychiatry and the law, in *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill*. The information contained in their book, as well as my own experiences, has brought me to the following conclusions. In the last forty years, many advances have been made in treating people with mental illness. By the 1950s, we had affirmed the biological basis for mental illness and discovered drugs to help alleviate its symptoms. We established hospitals to care for people with mental illness and were optimistic and excited about the answers we found. Mental illness was truly a disease and could be treated as such with hospitalization and medication. What a relief it was that we were finally able to do something. By 1955, 559,000 people were in state mental hospitals.⁵

My family was among many who during this time gratefully sought help for a family member with mental illness who was then hospitalized for "treatment." My grandmother was forcibly hospitalized after losing touch with reality shortly after the birth of her last child. When she dressed her youngest daughter in winter clothing and believed her to be freezing to death in the midst of summer, it became apparent that she needed help. She was taken away by several men in a large black car and remained hospitalized for a large part of her life. When long-term hospitalization was no longer considered appropriate treatment, she was placed in an adult foster home to live out her remaining years.

The 1960s saw the birth of the “antipsychiatry” movement, which took hold of public policy and has not let go. The sixties brought about, among other things, a counterculture whose members discovered the use of LSD when it was first introduced to them by their psychoanalysts. The effects of LSD and other psychedelics spread outside the control of physicians and further fueled the growing counterculture. The effects of the drugs on relatively sane people included intense anxiety, paranoia, and hallucinations. The effects were so similar to those of mental illness that LSD was believed by some to hold the answers to a controlled study of mental illness. For example, a federally funded project established at a veterans hospital in Menlo Park, California, paid volunteers to take LSD so that researchers could study its effects.

Ken Kesey, author of *One Flew over the Cuckoo’s Nest*, was among the volunteers. Shortly after participating in the research, he began working on a ward of psychiatric patients. It was after those experiences that he wrote the book which was later made into a movie about a man who attempts to free the “victims” on the psychiatric ward.

As the counterculture became political, the mentally ill and their victimization were thrown into the political arena and psychiatry became one of the enemies, going from savior to devil. This belief was even substantiated by some psychiatrists, led by Ronald Lang and Thomas Szasz. Their influence on the treatment or lack thereof for people with mental illness is still strongly felt.

The antipsychiatry movement led to a significant decrease in the credibility of psychiatry and to the association of mental illness with civil rights. Hospitals were seen as jails where people were held against their will with very little recourse and for no reason. Many stories were told of mistakes made in committing people who were perfectly sane, and published accounts detailed horrible conditions in hospitals owing to overcrowding. The dream of the forties and fifties became the nightmare of the sixties and seventies, and the pendulum began its journey toward the reality of today.

In the sixties, deinstitutionalization became the course of action supported and encouraged by President John Kennedy through his efforts at establishing community mental health centers, and reducing the population of people in mental hospitals. As of 1984, it numbered 116,000⁶ as compared to 559,000⁷ just twenty-nine years earlier.

The realities of deinstitutionalization have been much different from its seemingly intended effects. What awaited the deinstitutionalized person was not a warm welcoming community able to provide the needed treatment, but one that conveniently turned its back in an effort to protect its wallet. The needed dollars have not flowed to community services or housing in a way that would establish the needed support, treatment, and services for people leaving the hospitals and entering the community. Although community service represents 75 percent of the services provided to people with mental illness, it receives only 30 percent of the funding dollars.⁸

Paralleling the changes in treatment preference and modalities were changes in the laws and/or interpretation of the laws. We swung from the requirement of treatment or institutionalization, often court-ordered, to the right to refuse treatment regardless of one’s ability to determine reality unless the person poses an imminent danger to self or others. In Hamilton County, Ohio, of which Cincinnati is the county seat, this has been interpreted, at least by local physicians, to mean being homicidal or suicidal, with a plan and the perceived means of carrying it out.

In Ohio the law allows physicians or designated health officers (police officers and trained and certified others) who believe that someone who is known to be mentally ill, and is a danger to self or others or unable to care for basic needs, to sign a "hold" statement. It specifies that the person be hospitalized for seventy-two hours for observation to determine the need for further hospitalization. Once a hold is signed, the police can take the person, against his or her will, to a hospital. The only other option to force someone to obtain treatment is to go through the court system and have a judge order treatment. Hamilton County has one of the highest court-ordered treatment rates of counties in Ohio, according to its Community Mental Health Board, yet people needing medication adjustment and further stabilization provided by even a slightly longer stay in the hospital are being released without appropriate follow-up or are unable to access such needed services.

While working at Tender Mercies and attempting to obtain appropriate treatment for our residents, I would frequently run into this roadblock. We would have someone who was totally out of touch with reality, unable to care for personal needs, including medical needs, and we would be unable to activate the service delivery system because the person "did not fit the hold criteria." At times we were told this over the phone, without an evaluation of the individual needing services from the service provider. It seems to me that this practice stems from the interpretation of hospitalization as incarceration and that physicians and police are therefore fearful of violating a person's civil rights by hospitalizing them against their will unless they have committed, or admitted an intention to commit, a crime. The results are that unless an individual has reached the extreme of behaviors or is enough in touch with reality to volunteer to seek hospitalization, the door to possible assistance is closed.

In my opinion, this situation has been exacerbated by the closing of Rolmans State Hospital, one of the two state hospitals in Hamilton County. A facility designed to treat acute cases of mental illness, it was closed in an effort by the state to save money. Most of the staff and patients were transferred to the Pauline Warfield Lewis Center, a facility designed for long-term care, and not for severe acute cases. What was not well publicized was that many Lewis Center patients were discharged the year before Rolmans was closed. I found out about the discharges when I was discussing what I saw as an increasingly difficult and aggressive population of mentally ill persons coming to Tender Mercies' doors from the streets with the then medical director of Lewis Center. He informed me that he had been releasing "more patients over the last year" and wondered "how things were going in the community." I believe that the releases at Lewis Center had less to do with the needs of the patients and the ability of the community to provide the service and more to do with the anticipated closing of Rolmans and the need to make room for the transfers.

An example of the effects of this policy is a former resident of Tender Mercies who came to see me. He informed me that he had been discharged from the remaining state hospital that day and was told to go to the local mass shelter. One of Tender Mercies' staff followed up, and after several long calls to the hospital found that a room had been rented for him in a low-income downtown hotel for one night, but apparently no one had told him. In addition to being mentally ill, he also had an impaired IQ. His discharge was supposed to be provisional; if he could survive, he would be discharged to the community.

This man had left us previously, when he was in a very poor condition. After repeated urging and pleading by Tender Mercies' staff with his case manager, he was finally hospitalized after becoming so violent that he broke the ankle of one of my staff members with a metal chair. He is now back in the community with little or no follow-up to see if he can "make it," and we are urging and pleading again.

Ironically, despite the closing of state hospitals and lack of appropriate community services, Ohio has been ranked as one of the best places for services for people with severe mental illness. Since working at an agency that assists people who are supposed to be receiving these services, I find it difficult to understand how Ohio gained this ranking. It seems to me that we have not solved the sins of the institutions; we have only changed their face. Today the streets exist as an institution for many people with severe mental illness. The difference is that they have no bed to sleep in at night, no steady source of food, and their risk of physical harm has been increased. We have also designated jails as an alternative to institutions or hospitals.

An example of jails as an alternative in Cincinnati is the revival of an old panhandling law. Because some upstanding citizens complained about the panhandlers on city streets, police began arresting and jailing individuals who fit that description. Homeless activists and concerned others approached our city council for assistance; eventually, after much publicity in the local newspapers, the police significantly reduced their enforcement of the old law. Recently there has been discussion of a voucher system for panhandlers that would allow well-meaning or guilt-ridden citizens to buy and donate to panhandlers vouchers that would entitle them to, for example, a meal.

Cincinnati's criminal justice system is incredibly overcrowded without this influx of panhandler "criminals." There is no room in the jails for rapists and other perpetrators of violent crimes. Those wishing to file charges for assault are referred to private complaints; they meet with a mediator while the perpetrator roams free, rather than criminal charges being filed and the perpetrator going to jail. Clearly, everyone, including local citizens, police, politicians, and mental health and homeless activists, is frustrated by the lack of options for persons who are homeless, particularly the homeless mentally ill. How else can we explain such extraordinary measures as jailing panhandlers when rapists and other perpetrators of violent crimes go free? One of the residents at Tender Mercies was actually jailed for thirty days for jaywalking!

Ohio has a "housing as housing" policy for the treatment of persons with severe mental illness. The state previously provided dollars for such services as halfway houses, group homes, transitional housing for people who were homeless and had a mental illness, and supervised living with staff on the premises, including on-site case management. It seemed we had it all. It has been defunded by the state. There are now no programs with on-site service that the Ohio Department of Mental Health does or will fund.

The reason is the housing as housing policy, as well as decentralization of funding and services and a reduction in available state funds. The policy basically says that the state will provide funding only for housing without services attached and that any services provided have to be based somewhere else. The state will no longer fund any housing with "programs." According to the position paper describing the policy, "In summary, the Department intends to direct the large majority of its resources to development of housing as housing. Exceptions to this will be rare."⁹

The intent of this policy is to "promote the availability of decent, stable, affordable housing for all persons with mental illness including those with severe mental disabilities."¹⁰ The department is acting as a funding source for low-income housing for persons with mental illness. This, in and of itself, is an applaudable act; however, it has taken valuable resources away from community support services that were already insufficient, and it fails to coordinate services with housing.

While this policy change was taking place, the state began decentralizing services and reducing funding. The state hospitals are being turned over to the counties in which they are located or are being closed. As a result of these changes, the community mental health boards, which were initially designed to provide services within the community setting, are being burdened with the responsibility and the cost of the hospital closings and the resulting flood of people needing services. In addition, the state announced budgetary reductions, resulting in a large reduction for the Hamilton County Community Mental Health Board, and for all its contract agencies providing community support services. In sum, state-level cuts are forcing clients out of hospitals and cutting the much needed support services provided by community mental health programs. With the Hamilton County budget cuts, treatment options are being eliminated, and almost the only way to access treatment is again through the court system. It is not surprising that the county has one of the highest court-ordered treatment rates in Ohio. It is often the only option available.

One of the residents of Tender Mercies set fire to the building he lived in. When he was asked why he did it, he said that the voices in his head told him it was the only way he would receive help. He had been at the local state hospital for a while, but was released, still hearing voices. He went to the local psychiatric emergency room, was hospitalized for a few days, then discharged. He went to a private hospital, which refused to admit him. When he returned home, he propped his door open with his small refrigerator and started a fire in his doorway. The hallways had a twenty-four-hour smoke/fire monitor system. He was promptly arrested and taken to jail for aggravated arson.

In a separate incident, a man in a different Tender Mercies building set a fire that resulted in \$50,000 worth of property damage, physical risk to thirty-one people, and displacement of thirty people to other living arrangements. Tender Mercies staff had been pleading for appropriate services for him for several months. After the fire he was hospitalized for a short time; when he was released he moved into a building down the street. His new apartment was over a bar (he was also actively alcoholic). Within a week he started another fire in his apartment and was arrested for arson. If he was lucky, he would be probated by the court and receive the treatment and services he deserves.

Hamilton County is among the best in Ohio in the provision of services. Other counties, particularly rural ones, are having a much worse time. Clermont, a rural county that neighbors Hamilton and has a high proportion of poor people of Appalachian descent, suffered a failure of the county tax levy when voters failed to approve its passage. The county had to close some of its community mental health clinics. Such situations are mirrored across the state.

It is no mystery why the population of homeless people, specifically those with mental illness, has increased, given the changing policies and resulting lack of available support services and housing. The lack of a well-coordinated system of service

delivery, locally and nationally, brought about by the inability of people to access services, results in more people being homeless.

We must stop the pendulum from swinging again and again to the extremes. Today there is much talk about the need to reinstitutionalize many severely mentally ill people, particularly those who are homeless. So already the pendulum begins its decline. To address the issue of homelessness, we must address the true issues. To begin to alleviate the difficulties faced by so many people without access to the tools for basic survival, we must first acknowledge the right to these tools. Food, shelter, and security are the building blocks for all human endeavors. All must have access to these as a human right, if for no other reason. We must provide the needed dollars for development of permanent affordable housing and provision of adequate food and health care, including mental health care. In addition, we must provide an overlay of funding for education and vocational training for all who are in need.

I am proposing radical changes not only in the mental health system but for all service delivery systems. We must build a system, nationally, that coordinates, monitors, and funds programs providing for our citizens' basic human needs, including decent affordable housing, food, health care, education, and employment. The United States currently funds one of the largest military communities in the world and derives very little social benefit from it. We must learn from the failures of the Soviet Union, one of the other military communities that robbed its citizens of the basic tools of survival. The Soviets did not come to the bargaining table due to our military might, but because their economy toppled in supporting such a military community. We are headed down the same path. We are fighting a "war on drugs," sending people to live in space at extraordinary expense, bailing out banks and savings and loans, paying farmers not to grow food; the list goes on. Elimination or substantial reduction of spending on these endeavors would allow us to begin anew, to guarantee our citizens decent affordable housing, food, health care, education, and vocational training. We would no longer need welfare handouts or the stigma attached to them; instead, as with Social Security, we would have certain rights and not have to apologize or plead for the basic tools of survival. The social and economic benefit would be tremendous.

To return to reality: given that we are not going to begin anew anytime soon, what can we do with what we have? We must work to increase the funding of affordable housing and not allow developers to take future funded units off line; they must remain affordable housing. The federal government must get back into the game of funding affordable housing, and states must continue to look for creative ways to finance it.

The National Institute of Mental Health must receive the funding needed not only to carry on research and technical assistance, but to establish minimum standards and the ability to monitor and fund programs for community support. These must include the following.

1. Case managers for persons who are chronically or severely mentally ill should average no more than twenty-five clients per caseload.
2. Skill training, and other housing support, must be made available to all who need it.
3. Psychiatric backup, separate from attending psychiatrists at emergency rooms, should be available to case management teams twenty-four hours a day. In addition, psychiatrists should be available to see their patients as often as necessary.

4. A range of treatment options, including housing, should be available to people based on their needs.

5. Laws pertaining to forced treatment should be redefined to address the issues of danger to others and self and to include being detached from reality and unable to determine appropriate treatment, as well as being unable to care for self.

We must centralize the coordination of services, without a huge bureaucratic overlay, so that services can be provided effectively and compassionately. We must say no to the swinging pendulum and find the steady ground based on long-term solutions, not short-term politics. ♪

Notes

1. R. B. Reich, "As the World Turns," *The New Republic*, May 1989, 23-28.
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3. F. G. Reamer, "The Affordable Housing Crisis and Social Work," *Social Work* 34 (January): 5-9.
4. J. Morrissey and D. Dennis, "NIMH-funded Research Concerning Homeless Mentally Ill Persons: Implications for Policy and Practice" (Washington, D.C.: U.S. Department of Health and Human Services, December 1986), 15.
5. Jean Isaac and Virginia Armat give an excellent historical context in *Madness in the Streets: How Psychiatry and the Law Abandoned the Mentally Ill* (New York: Free Press, 1990). It is well worth the reading and gives a much more in-depth view of these events.
6. Committee on Government Operations, "From Back Wards to Back Streets: The Failure of the Federal Government in Providing Services for the Mentally Ill" (Washington, D.C.: U.S. Government Printing Office, 1988), 3.
7. Isaac and Armat, *Madness in the Streets*.
8. Committee on Government Operations, "From Back Wards to Back Streets," 14.
9. Grace Lewis, "Housing as Housing: Discussion Paper," Ohio Department of Mental Health, July 1988, 7.
10. *Ibid.*, 1.

Counting the New York Homeless

An Ethnographic Perspective

Kim Hopper, Ph.D.

Significant ambiguities inhere in the operational definitions of “site” and “selected components of the homeless population” used in the 1990 S-Night Count. Ethnographic methods offer a useful corrective. This article, covering research that was part of a larger project evaluating the S-Night count, describes a brief ethnographic inquiry into the ecology of public spaces occupied by the homeless poor in New York City. Problems in implementation, surprising ease of access, patterns of mobility and prevailing norms from site to site, and the tenuous character of the street sites are reviewed, as are implications for future enumeration efforts.

The Census Bureau’s interest in the numbers of demographics of homeless, and in the institutions catering to them, dates at least from the time of a special enumeration of Minneapolis’s skid row in the mid-1950s.¹ The bureau stimulated renewed interest in the problems of enumerating such populations by funding several pilot studies preceding the 1990 Decennial Census² and a set of assessments of the 1990 S-Night street and shelter enumeration effort in sections of Chicago, Los Angeles, New Orleans, New York, and Phoenix. Several companion studies were undertaken as part of the New York effort.³ This article reports the findings of a brief ethnographic inquiry into nighttime habitats of the street-dwelling homeless.

Ethnography in the Annals of Homelessness

Historically, American ethnographers have made signal contributions to the documentation and interpretation of the lives of homeless men and women, in Chicago and New York especially. The pathbreaking — and for the most part, unpublished — work of Nels Anderson⁴ and Charles Barnes⁵ on the municipal lodging house in New York; Anderson’s earlier work⁶ on “hoboemia” in Chicago; the later, Depression-era studies of “shelterization” by Sutherland and Locke in Chicago;⁷ Stiff’s vade mecum for the road;⁸ Caplow’s study of “transiency as a cultural pattern”;⁹ and Wallace’s analysis of the “subculture” of skid row¹⁰ — all charted territory that would repay scholarly forays for years to come.

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An urban misfit of unusual fascination, the "skid row man" was closely scrutinized by sociologists — and the occasional anthropologist — in the postwar years, usually "for reasons that [had] nothing to do with the relative urgency of homelessness as a social problem."¹¹ A team of sociologists headed by Bahr¹² descended on the Bowery in the 1960s for an extended examination of the vagaries of "disaffiliation" practiced there. At about the same time, an anthropologist who set out to study the developing culture of a new alcohol treatment center wound up doing an exposé on the abuse of tramps in the Seattle jail.¹³ In the early 1970s, it was still possible to find rich dissertation material in the timeworn life ways of "fruit tramps" in the orchards and on the railways of the American northwest.¹⁴ But already, a new variant of homelessness was emerging, one that would define its urban niche not by work or absence of ties, but by residence in the "interstices" of public space.¹⁵

In the late 1970s and throughout the 1980s, ethnographic studies were undertaken in New York,¹⁶ Phoenix,¹⁷ Syracuse,¹⁸ Los Angeles,¹⁹ Santa Barbara,²⁰ Albuquerque,²¹ Connecticut,²² and Austin.²³ Ethnographers participated in larger, mixed-methods studies in Los Angeles,²⁴ New York,²⁵ and Baltimore.²⁶ Most recently (1990–1991), a full round of research demonstration projects, funded by the National Institute of Mental Health to serve homeless men and women with severe psychiatric disorders, each included one or more ethnographers as part of its evaluation component.

Contributions of Ethnography to Understanding Homelessness

The earliest and still most distinctive feature of the ethnographic approach is the reconstruction, "from the native's point of view," of what is often a highly charged and badly misunderstood cultural niche. Spradley²⁷ and Wiseman²⁸ mounted careful studies of homeless men and their interactions with agencies of social control (the police and alcohol treatment centers, respectively) and took pains to craft a distinctive view that was in each case at striking variance with the official perspective on jail or treatment. Competing perspectives on the utilities of public shelter and, earlier, the almshouse can be documented as well.²⁹ Closely allied with the shift in vantage point is the attempt to situate particular practices or beliefs within a larger context, difficult as it may be to determine the proper boundaries of that "whole."³⁰ Other features of the ethnographic turn that are only now appearing in studies of contemporary homelessness: a commitment to the rigors of sustained fieldwork and to the seasoned version of street lore that only the long view can offer; an insistence that, rich as the heuristic value of the "adaptation" premise has been, it is also essential to assess its limitations and to show how patterns of accommodation change over time and across contexts; and closer attention to the perils as well as the benefits of participant observation.³¹ Finally, a comparative perspective is beginning to take shape, as in the question of how distinctive a group within the homeless the habitually street dwelling may constitute.³²

Study Description

It was this domain of the street we undertook to study. Mindful of the strengths of the ethnographic method, namely, close documentation and extended periods of

observation and interview, but working under very real time constraints, we designed a “brief ethnographic” inquiry into some of the informal shelter devised or appropriated by the homeless poor in public spaces. On five successive nights, a small corps of participant observers was dispatched to seven assigned sites, there to pass the night as if homeless themselves. The research group was made up of graduate students in sociology and anthropology from the New School for Social Research and Rutgers University, a number of whom were international students; a physician’s assistant; an out-of-work musician; a graphic artist; two shelter workers; and two homeless women who received special permission from a city shelter director to participate in the study. Their charge was simply to describe the nighttime use of public spaces by homeless individuals as well as any competing uses of those spaces.³³ Our aim was twofold: to “disaggregate the street” — to document with as much precision and local color as we could muster the differences in numbers of apparent homeless people, mobility, rules of conduct, and textures of life in these half-forgotten byways; and to derive implications for the assessment of attempts to enumerate the street-dwelling homeless population.

Design

Sites were chosen to yield a mix with respect to size, stability of population, and location (indoor versus outdoor). For purposes of minimizing the intrusiveness of our observers, all the sites but two were in the moderate (at least twenty-one) or large (fifty-one plus) size range. The exceptions were both outdoor sites: a plaza with, it turned out, very few occupants, and a small cardboard box, tarp, and sleeping bag “settlement” with between fifteen and twenty occupants (see Map of Site 6). The other sites included two large transportation terminals — one of which was actually a conglomeration of a number of distinctive subsites — and three subway stations (see Table 1).

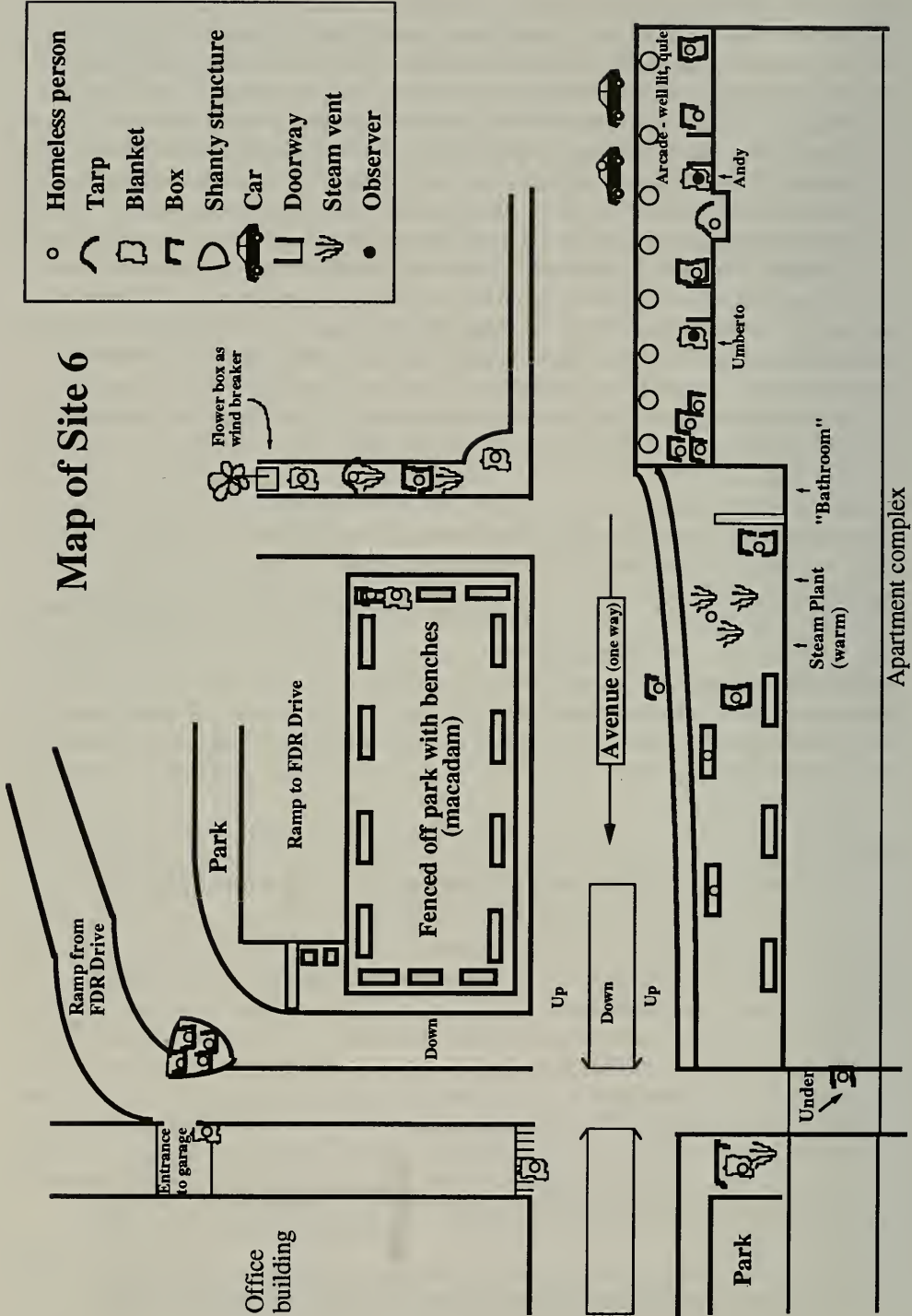
Table 1

Location of Ethnographic Sites by Size and Census District
(Entry in table is study identifier of site)^a

Size ^b	District			
	DO2201	DO2203	DO2204	DO2206
0-6				7
6-10				
11-20			6	
21-50	2a and 2b	4	5	
51+	1a and 1b			
	3			

^aSite descriptions: Site 1a and 1b = two separate “zones” in large train station; 2a and 2b = two separate “zones” in large subway station in financial district; 3 = ferry terminal; 4 = west village subway station; 5 = midtown subway station; 6 = shanty settlement, East Side; 7 = outdoor square, midtown.

^bBased on “best estimates” acquired during repeat enumeration study, as described in K. Hopper, “Final Report: Repeat Enumeration, Structured Interview, and Brief Ethnographic Studies of the Street Census Project” (Washington, D.C.: U.S. Bureau of the Census, Center for Survey Methods Research, 1991b).



Participant observers typically arrived on site around midnight and stayed until 6:00 A.M. or morning wake up. Several teams found it useful to vary their routine, sometimes arriving earlier, sometimes staying later, in order to observe and interact with residents as they bedded down for the night or awoke in the morning. At sites where occupants were frequently awake throughout the night, observers made efforts to speak with them. Field notes were kept surreptitiously — hastily scrawled during trips to the bathroom or concealed by a blanket or piece of cardboard — and were formalized as soon as possible after observers left site each morning.

The Problem of Artifice

As the scope of work grew progressively more detailed and the demands on observers mounted, the research team found itself beset by a host of doubts about the quality of the data likely to be obtained with brief ethnographic methods. Most of these misgivings turned out to be unfounded. The fundamental problem was not, as the principal investigator had anticipated, the provisional character of the “ethnographic validity”³⁴ to which these observations and reports could lay claim. Enough rough corroboration was obtained from the various observers, who logged and documented uninterrupted hours in diverse but kindred settings, to permit some preliminary judgments about what was idiosyncratic and what characteristic about the street sites. Nor did the problem arise from restricted access. Indeed, project participants were uniformly of the opinion that the degree of access they were accorded would have been difficult to achieve in any other way, especially in so compressed a time period. Rather, the problem had to do with the terms and conditions under which such access was obtained.

Although strictly instructed to respond to direct inquiries about their purpose with an accurate thumbnail sketch of the study (“I’m part of a study of the nighttime use of public space in the city”), *without exception* the participant observers found themselves unable to drop the pretense of homelessness. Each of them, even those confronted by sometimes surly accusations of fraud, maintained the fiction of being homeless. On occasion, this meant going to great lengths to devise intricate narratives as to how they had arrived on the street. Throughout most of the study, this spontaneous strategy proved unproblematic; on the contrary, it became a matter of pride for some to be able carry off the impersonation successfully. Toward the end, however, a different response began to surface, one that would dominate postproject discussions on the ethics of field technique.

Put simply, a number of participants came to feel that the artifice was unjustified, that whatever might be learned about the gritty particulars, or even the unexpected grace notes, of street life would be tainted by the method of acquisition. Not surprisingly, the active deception required in direct personal interaction proved more troublesome than the passive version exercised in on-site observation. There may be no better way of documenting spontaneous offers of aid on the street than to be a recipient of such aid oneself, for example, but that doesn’t rid one of the sense of having cheapened the gift by virtue of the counterfeit appeal. Moments of shared intimacy, of personal revelation — even when they had been honestly reciprocated by research workers drawing upon their own personal histories — were especially likely to provoke guilt and discomfort. A number of study participants were nagged by the sense of having tricked people out of what was, for many of them, among their few remaining possessions: their capacity for connecting with another in distress.³⁵

The project improvised a number of methods for dealing with this issue after the fact, ranging from extensive group discussions and dissections in a graduate level “field methods” seminar to one-on-one consultations with the principal investigator (P.I.). Most common were informal discussions among project participants themselves, for many of whom this was their inaugural field experience. The most effective preventive measure would have been close monitoring and supervision, along with regular debriefing of field workers as the project progressed. Given the operational structure, namely, the demands on the P.I. of running three separate but simultaneous studies, this was infeasible and, in retrospect, such a structure was a mistake.

The ethics of “disguised observation” in social research have been debated for some time. The classic positions for and against were laid out by Denzin and Erikson,³⁶ but the issues remain far from settled.³⁷ Anthropological fieldwork that attempts to “study up”³⁸ or to investigate disavowed cultural beliefs and practices³⁹ poses the quandary in especially bold face. This project had hoped to avoid the more troubling of such dilemmas — active deception as opposed to unobtrusive observation or eavesdropping in consensually defined public settings — by directing the research team to respond honestly to any query about his or her presence there. In the press of the situation, that direction gave way to a determined effort to be as honest as possible without blowing one’s cover. Further analysis of the ethical issues raised here is beyond the scope of this article but will be reported in a future publication.

Findings

Much attention has been paid in the press to the deficiencies of the “homeless count,” which took place on “S-Night” (March 20–21). Critics have complained of inadequate coverage of homeless “congregating sites,” the erratic performance of street enumerators, and the sometimes surreal presence of the media monitoring the event. Journalistic accounts of the process suggest a great deal of latitude in the frontline interpretations of Bureau enumeration instructions.⁴⁰ This brief ethnographic study offers an instructive complement to the harried formal count. As efforts have intensified to displace street dwellers from their traditional redoubts (about which, more below), the yield of close observation studies, even on the limited scale mounted here,⁴¹ provides a source of data that could usefully inform policy debates on alternatives to the street and, in the event, enhance efforts to enumerate this shifting population.

Transiency and Stability at the Sites

Not only did the ethnographers prove of variable reliability in assessing relative proportions of stable and transient residents at the sites, but the ecology of the sites themselves was quite uneven in permitting such assessments to be made. Sheer visibility of occupants, and the ensuing difficulties of establishing an individual’s identity and tracking his or her presence from night to night, was the most frequently encountered problem. Although some ethnographers managed to do it, making the rounds of the premises from time to time to take an accounting of occupants was totally out of the question for others.⁴² A further problem was the size of the sites and of their resident homeless populations: where we expected large numbers, we divided the site into “zones” and assigned ethnographers to what were, in effect, specific areas of the larger site. Obviously, this introduces difficulties in tracking any individual who,

though he or she may move around within a site from hour to hour or night to night, remains "on site" for the duration. Duplication in some instances was unavoidable, and estimates of transiency and stability are at best rough measures.

With such caveats in mind, see Table 2 for a summary of our conclusions regarding the stability and transiency of site occupants. Note that in all but one of the nine sites/zones covered, at least 60 percent of an average night's occupants were "regulars," present for the great majority of the time our ethnographers were observing that week.

Table 2

Transiency versus Stability at the Ethnographic Sites

Site	Estimate "Transient" ^a	Estimate "Stable" ^b	Range of Occupancy ^c
1a	20 on "party nights"	80% regular	40–60
1b	20–30	approximately 75% "regulars"	80–140
2a		approx. 60% there at least half of nights observed	23–31
2b	1 of 3	2 of 3	3 ^d
3		75%–85% "regulars"	21–40
4 ^e		approx. 64% there at least half of nights observed ^f	7–14
5		60% there for 4 of 5 nights	25–40
6		60%–75% there for 4 of 5 nights	18–30
7	15–19 others observed once or twice that week	approx. 66% ^g	7–15

^aDescriptions and measures vary owing to uneven, nonstandardized, and often incomplete character of fieldnotes; to difference in fieldwork technique (relative emphases on observation vs. interaction); and to differences in visibility, identifiability, and numbers of site occupants.

^bEntries in this column pertain to average night's population.

^cNote discrepancies when compared with repeat enumeration counts; ethnographers counted only those they considered to be homeless and in their immediate sector of the site. For example, observed range of Site 3 (ferry terminal) falls far short of range of 47 to 86 recorded by repeat enumerators; similarly, at subway station (Site 4), range of 7 to 14 contrasts with enumerators' range of 20 to 60. In each of these, obvious commuters (a class especially numerous on weekend nights) were excluded by ethnographers.

^dBetween 6 and 30 observed on passing subway trains.

^eAmbiguities of site definition compounded by practice of some residents to pass at least part of the observational period on the trains.

^fBased on fourth night's tabulations; on fifth night, station was cleaned and a good number of regulars never showed up, slept elsewhere, or boarded subway trains.

^gSeven regulars each night.

The Order of the Street

Notwithstanding the differences observed from site to site, the most salient lesson to be drawn from this brief study can be put simply: "the street" is not now, if it ever was, synonymous with mere anarchy. Even in these lower depths, distinctive orders and routines prevail. Much as the cadre of street dwellers impressed the observers as distinctly "other" — the classic subject of fieldwork — they also met and, in the com-

pressed space of five nights, came to know people who themselves could pass for kin or acquaintances. At several indoor sites, one or two of the “regulars” actively checked out our positioned newcomers and, finding them no threat, offered brief tutorials in the lore of street life. They recounted — at times in painstaking detail — the working “rules” of that space, the schedules and addresses of local soup kitchens, the locations of prized out-of-the-way havens, the names of potential sources of aid. At a train station, a small group of the homeless residents was observed to come to the aid of a commuter suffering an epileptic seizure, while “respectable” passersby passed her by.

Beat cops, security guards, and token booth clerks were seen at certain sites awakening occupants in time for work each day. In places where conviviality stretched well into the night, the observers made the acquaintance of surprisingly well-read conversationalists and found themselves arguing the relative merits of city shelter and housing policies, debating the value of the census, and bemoaning the state of the job market. Two observers shared the bounty when restaurant workers dropped off leftover baked goods on their way home; two others watched as two members of a wedding party, still in formal attire, made their way into a midtown subway station late one night to offer residents the remnants of the cake.

In contrast to what has been reported elsewhere, direct questions of a highly personal nature — Are you homeless? How did it happen? — were frequently asked of our observers in conversation with other site occupants.⁴³ Even fragments of family history commonly found their way into casual talk. Whether this has to do with changing norms of interaction on the street, a diminished stigma attached to the condition itself, or specific variations from site to site, it is too early to say.⁴⁴ Clearly, as a journalistic account of a shantytown in New York also attests, such a picture contrasts starkly with the received and still prevalent image of homeless individuals as “disaffiliated.”⁴⁵

These observations of spontaneous aid and companionship offered by people so obviously needy themselves, so grossly at odds with the predatory picture of homelessness popularly portrayed, clearly merit greater attention.⁴⁶ It is worth remarking here that these varied types of assistance were tendered even when it was apparent that the veteran street dweller harbored strong suspicions about the reality of the homelessness our researchers professed. There were a few exceptions, as when a snort of dismissal or expression of real hostility followed upon the realization that what one had taken for the genuine article was a poseur instead. Pressed for money by a young man panhandling at the southwest corner of Central Park at 2:30 A.M., a woman researcher offered a spare set of gloves instead, something, apparently, very few homeless persons are in a position to do. The response: “His eyes became hard and he said in a low, vicious voice, ‘Get out of here. Get out of here fast. Just get out.’” The ethnographer further comments: “It’s as if the truth were written in neon on my face . . . I am clearly a charade — a person privileged enough to play at being homeless . . . A truly homeless person might, understandably, be furious. (Kennedy field notes, March 24, 1990)

In somewhat greater detail, significant variation was found from site to site with respect to the following.

1. *Norms of behavior and the division of public space.* the dominant site “themes” were three: all-night emporium, stable refuge, party spot. In larger sites, two or

more could coexist in distinct “zones,” as, for example, a clear “no smoking” — of crack — section in one transportation depot. Some areas had highly specific functional demarcations: a cardboard box where a brisk trade in drugs was going on throughout the night; a designated track platform where sex could be traded for drugs or money; a section of a waiting room where it was understood that marathon drinking/conversing could take place; an entire subway station where even the insomniacs took care to keep their voices down so as not to disturb the sleep of their compatriots. There were sites (or zones) where quiet was unattained before 4:00 a.m. and, in the event, lasted a mere two hours; others where straight, that is, nonhomeless, traffic continued all night. There were indoor places where great value was attached to a few hours of uninterrupted sleep. “This place is like a dormitory,” remarked one observer of a midtown subway station. Said of another in the financial district: “This is really a very peaceful station. The regulars keep to themselves and sleep most of the time.” (Grieshof, Stevens, and Tejada field notes) An outdoor encampment was remarkable mainly for the mute witness to homelessness given by the cardboard boxes arranged there.⁴⁷

2. *Support of companions.* regardless of the prevailing site ethos, on any number of occasions acts of mutual support were observed — from the simplest act of throwing a blanket over a companion who had just passed out, to the more risky business of breaking up fights so as not to attract the attention of police, to the common courtesy of “watch[ing] my things” while someone went to run an errand or use the bathroom. At times, it was an articulated ethic of “we take care of [or look out for] each other.” More often, it seemed to be simply a tacit rule of survival. Most perishable foods were readily shared. When midnight soup runs arrived, it was understood that a general reveille would be sounded. Snacks and alcohol especially, but also money and cigarettes, were the most commonly shared items.⁴⁸ Even the yield of panhandling was at times brought back for collective consumption. At present — and a precarious present it may well be — sufficient food appears not to be a problem on the street, given the host of organized and spontaneous charitable sources. Other necessities, less often remarked, remain in scarce supply. For women, it turns out that menstrual pads or tampons, which are difficult to obtain and costly goods, are normally available only in the shelters. One observer stationed near the southwest corner of Central Park said they were a frequently requested item (Kennedy field notes).

3. *Ethnicity.* the ethnic mix was pronounced in some sites — a subway station near Wall Street counted white, African-American, Jamaican, Hispanic, and Indian residents one night — and much less so in others. No clear pattern was observed by geography or type of site. And although casually racist slurs — usually by elderly white men about younger black men — were overheard by our ethnographers, they were generally not made in the presence of members of the offended group. In the few instances of overt fighting observed, participants appeared to be of the same ethnicity.

4. *Gender.* women clearly constituted a minority on the street, but their relative numbers varied from site to site.⁴⁹ Safety and privacy were clearly uppermost in the minds of women residents especially. A number of them sleeping indoors in a vast transportation terminal were observed carefully fashioning their belongings into the shape of a sleeping figure, which they then arranged next to themselves; three elderly Jamaican women assumed regular spots in adjoining toilet stalls in the

women's restroom at one terminal and stayed in verbal contact throughout the night.⁵⁰ Others covered themselves with blankets, shawls, sweatshirts, or overcoats to render themselves genderless in the eyes of potentially predatory observers.

Sex was openly traded for money or drugs at a few sites. Impressions are sketchy at this point, but for the most part, this appeared to be either within group — “You got the wine, you get a ride” (Lambert field notes) — or between residents and their usual suppliers. There were instances (related or observed) when the transaction was clearly commercial.⁵¹ More generally, homeless women appeared to be fair game to all manner of abuse on the street. In the space of five nights, four women on our research team were approached by *nonhomeless* men seeking cheap sexual labor.⁵² Three were promised room and board in return; a mere cup of coffee was held out to the fourth. In each instance, the offer was made insistently, so much so in one case that a male homeless companion intervened on the woman's behalf.

5. *Responsibility for shared space.* the practice of cleaning up after oneself, removing and storing the traces of bedding in particular, was especially strong in public places given over to alternative use during the daytime. Regulars were quite clear that such a practice both ensured continued access and protected their belongings from being thrown away. Clear understandings were in effect in most settings regarding provisions for personal hygiene: public toilets were used (one was kept open by subway maintenance specifically for the purpose); individual containers were filled and discreetly emptied into a floor drain or the street; sections of a space were given over to the purpose (and would-be violators loudly advised of the rule). In only one site — a large outdoor traffic circle/plaza, where residency frequently changed from night to night — was there ambiguity regarding which areas were to be used for relieving oneself.

The issue of personal space and respect for individual territoriality is more complex, ranging as it does from the simple gesture of not stepping on another's strip of cardboard in a transportation terminal to familiar rituals of “knocking” on another's makeshift house in more elaborate settings.

6. *The support and complicity of cops, clerks, and security guards.* standing arrangements were observed in two sites where both token booth clerks and beat cops awakened a few residents for work. It was apparently common practice to ignore the token drops at turnstiles in subway or ferry stations, and residents were not harassed for the infraction. In at least one site, residents were on a first-name basis with a policeman who took it upon himself to ask paying passengers to move on when they verbally harassed the homeless. (On one such occasion, his partner later distributed muffins, obtained at her expense, to those still awake.)

7. *Architecture of improvised shelter.* homemade housing varied: bedrolls and tarps; cardboard, plastic, and wood slatting creations; overturned postal carts; mini-hovels, one fashioned from stacked plastic milk bottle carts (filled with magazines for stability) across which boards are laid and under which two canvas postal carts are parked; and substantial structures complete with electricity and wood stoves, which did not, to our knowledge, appear on the submitted lists of “addresses” to be covered by the standard census. Our observers also noted what has since been recognized as the widespread practice of homeless people camping out in the locked areas housing automated teller machines in the city's numerous banks, none of

which, it is worth noting, appeared on the Census Bureau list of “predesignated” sites where homeless persons congregate.

Violence

But even an observer attuned to the apparent orderliness of much of the nighttime use of public space could not ignore the rough and seamy side of the street. Time and again, the research team found evidence of the traditional furies of street life.

1. *Trafficking* in outlawed substances was commonplace, sometimes done openly and sometimes behind closed doors. All night carousing was the norm at a few sites, and the varieties of substance abuse ran the gamut from teenage “crackheads” to twenty-year veterans of the bottle. The brief bursts of violence — usually clumsy scuffling, though knives and clubs were used on occasion — and staccato rhythms and activity and talk characteristic of some sites were thought by our observers and some of their homeless companions to be directly related to the consumption of drugs or alcohol.

2. *The routine indignities of street life* were readily apparent: the precarious status of most makeshift arrangements; the scarcity of common amenities — tampons for women, toilets and places to wash up, the haven of a private spot; the capricious enforcement of antiloitering laws, whether in forbidding someone to sit or in ridding a subway station of all nighttime occupants; the scorn and verbal abuse of passersby, whether outright harassment or the refusal of a fellow subway rider to acknowledge a polite request for the time of day; the constant vigilance required of an unattached woman. For the most part, these were not articulated complaints, but rather part of the expected costs of business on the street. On occasion, with more regret than bitterness, it was voiced: “You get no respect; [either] people look right through you or they’re afraid.” (Salmon field notes)

3. *Random acts of violence* did make things dicey at times: Two of our observers were dozing on a subway platform not thirty feet from the stairway where another resident’s throat was cut early one morning. They learned of it only when signaled by the commotion attending the arrival of an ambulance. (Dozier, Herrera field notes)

How the Outside World Intrudes

Perhaps most telling — because most unexpected — were the ways in which the outside world, as memory or live presence, intruded. In our preparation of the observers, we had made a point of stressing that such research was not without its peculiar hazards, but had anticipated that the threat, whatever form it might assume, would come from within the sometimes congested ranks of the street dwellers themselves. We had not foreseen that the more vicious and common sources of danger would come from without.⁵³

The most frequent disruption was that posed by routine maintenance, often led and bolstered by security. Would-be sleepers in several sites were awakened at odd times during the night and told to move on so that the space could be hosed down, swept, or otherwise cleaned. At three indoor sites, accommodations had been reached with the residents: at one, they simply made their way onto subway trains for the duration of the maintenance; at the two others, the groups moved en masse to sections of the site that had already been cleaned and back again when maintenance was complete. Some residents regularly took part in awakening others and advising them of the impending

time to move; incidentally, they were the same ones who tended to assume the responsibility of notifying others of the arrival of midnight food deliveries.

Less common were instances of police and "spree" harassment. With respect to the first, several instances were reported of police or security guards awakening, forcing sitting persons to stand, or "evicting" residents for no apparent purpose other than reminding them that their continued presence there was by no means assured. At times, too, enhanced police presence appeared to be intended to reduce use of this particular site. With respect to the second, on several occasions packs of young males ran through the sites where our observers were stationed. One group professed loudly to be conducting a "census count"; another simply made noise to awaken people in a hallway; a third ran through an open square on the Upper West Side; a fourth actually stopped to confront individual homeless men and women trying to sleep on the floor of a train station. One of our ethnographers, Dorinda Welle, described the scene.

At 4:00 A.M., a group of four white teens came through our area, kicking old people, telling them to get a place to live, "get a job," "get a home," "wake up, grandpa," "hey, assholes," "you garbage people," etc. One stole the single roses wrapped tightly in plastic that one sleeping man sells during the day for \$1.00 each. The teen gave the roses to young women standing by, watching. Then these guys came over to us, looking at me (lying down, but awake and paying attention to their movement). One guy stood at the foot of our blanket and stared down at me. I stared back. D. woke up, put his hand on his switchblade in his pocket, but didn't take it out. He looked at me from under his cap brim, signaling me to be cool, be still. I really thought these kids were going to beat us up. Looking the one in the face, I couldn't determine the reason for the hate I saw there — Was it for being homeless? Being female? Being white and homeless? Being white and hanging out with blacks? Finally, I looked at D. again; he seemed to say "Do something . . ." and I said really loudly (but not shouting) so perhaps the cop nearby could hear me: "Get the hell out of my face!" The guy said "bitch," kicking my foot before he slinked off to his friends. D. said: "Good to say it loud. The cops don't want to see anybody get hurt too bad here." (Welle field notes, March 25, 1990)

The second type of interaction has already been alluded to in the citations of assistance and succor extended across the homeless divide. In one subway station, a security guard made a point of addressing the sleeping men there as "gentlemen" when he woke them, so that the night's cleaning could take place. As remarked earlier, token booth clerks routinely turned a blind eye to homeless patrons passing through turnstiles without paying. The solicitousness of cops toward regular residents was far more impressive than the occasional acts of petty harassment.

Eloquent testament to the sort of unexpected kinship that can arise comes from an incident involving the same D. mentioned above. It is voiced in the course of his trying to console a young West Indian woman, not homeless herself but new to the city and visibly distressed at the sight of "all these black folks here." Having established that he also had family in St. Thomas, D. took it on himself to explain.

As much as it breaks my heart to be homeless, it really breaks my heart that you have to experience this shock. Let me tell you that nobody wants to be here, but here is where we're safest for now. . . . It's a terrible thing, but you have to understand that we survive, we take care of each other. You have to understand that this is a condition, this homelessness; it's not who we are. (Welle field notes, March 25, 1990)

Finally and somewhat more tentatively, the presence of the “outside” world was felt in the tug of memory and shape of things hoped for. Anyone who has spent the slightest time talking with street dwellers knows of the loneliness of the street. Nonetheless, our observers were unprepared for encounters with men and women, not much older than they, who told of yearning for intimacy and the privacy to practice it. We hadn’t anticipated how much of a former life would continue to shadow, even haunt, the survival necessities of street life. “You can’t have a relationship when you have no self-respect, no home, no money. You have to take care of yourself, and it’d just drag you down.” Couples were comparatively rare in open street sites (not the shanties) and were seen as peculiarly vulnerable to the manifold threats of the street, male partners being repeatedly warned to keep a close eye on “their” women. One street veteran confided to a pair of observers the location of a safe spot in an abandoned bus tucked away in a little-used area of Central Park, where a few hours of uninterrupted privacy might be had. (Greshof, Salmon field notes)

Implications for Enumeration

The findings of the brief ethnographic study suggest that several modifications are in order if a more accurate estimate of the number of individuals in “selected components of the homeless population” is to be obtained.

First, as has repeatedly been illustrated in the foregoing account, there are immense logistical difficulties presented when a street “site” is taken to be analogous to an “address” and enumerators are dispatched accordingly to do their counting. Descriptive ambiguities abound with respect to the precise location and identifying markers of sites; the boundaries of the area designated by a single site, especially where two or more may be contiguous; the contingencies of access to sites over time; and the still mysterious processes by which congregating sites take shape, are occupied, and the terms of staying or leaving are negotiated with those who have control over such sites. Additional difficulties are introduced by the evidence of mobility on the part of site occupants, even during the relatively small time window allotted for the count. Further problems arise from the sheer complexity of the site ecologies themselves, such as barriers that may render an occupant “invisible” to an enumerator unfamiliar with the details of the site layout or unwilling to explore its further reaches.

Many, if not most, of these difficulties could be resolved by appropriate use of sampling methodologies and elimination of the notion of full enumeration. One possibility would be a two-stage process composed of an inventory followed by local counting of sampled sites. A team of research workers would first establish the universe of sites at a time close to that of the subsequent count, preferably stratified by likely numbers of occupants. Statistical techniques analogous to those designed to estimate the number of species in a region would be used to estimate the number of unlocated sites.⁵⁴ The field staff would then draw up detailed maps of those sites actually to be visited, and the same team would be deployed in the actual count or estimation of a sample of the sites identified in the first stage. The results here, combined with those in a companion report, argue strongly for utilizing such statistical approaches to the estimation of the size of fugitive populations in preference to the impossibility of raw enumeration and its implied (but spurious) greater precision.⁵⁵ The significant progress made in the theory of estimating animal abundance and

species estimation suggests that, in combination with statistical techniques specifically designed for the problem at hand,⁵⁶ viable alternatives to head counts exist that would be both cost-effective and accurate.⁵⁷

Second, whatever method — enumeration or statistical estimation — is chosen, if sites are to remain the unit of observation it is essential that the list used be pre-viewed, corrected for inaccuracies, carefully explored to establish the individual areas and boundaries of sites, and that workers be intimately familiar with such areas before the count.

Third, with respect to the problem presented by residents in shantytowns who, although present, were invisible to enumerators on the night of the count, one immediately practical option would be to add such sites to the list of “addresses” in the “List/enumerate” category to be visited by Census Bureau employees during normal working hours, thus ensuring their coverage.⁵⁸

Fourth, with respect to the bureau’s insistence that only “selected components of the homeless population” would be enumerated, given the evidence of significant “contamination” in some sites of what would conventionally be considered a homeless street population, indications that the homeless poor themselves were generally cooperative, and the willingness overall of those approached to admit to being homeless, we would recommend that the bureau consider using a screening question to establish homeless status, at least in areas where this may be in doubt.⁵⁹ The outstanding issue that bulks so large in the enumeration problems presented by poor city residents — What is the incentive to cooperate with a venture from which few benefits appear to derive and to which much suspicion is attached? — did not appear to be a salient feature of 1990 S-Night experiences.⁶⁰ On the other hand, how benign can a “dead-of-night” interview be made to appear?

Fifth, one alternative to dead-of-night enumeration is to engage homeless individuals in places where concrete services are offered under circumstances that are at least more conventional than 3:00 A.M. encounters on the street. But in addition to established facilities as soup kitchens and drop-in centers, in places like New York substantial growth has occurred in mobile services to street populations (food and clothing distribution in particular). An ironic side effect may well be that the utility of day service centers as proxy sites for drawing samples of the street-dwelling homeless is badly compromised. Although tested and found reliable in one site⁶¹ and currently under investigation by the Census Bureau in another,⁶² it was by no means clear that our respondents made regular enough use of stationary services for this procedure to work. It seems especially questionable for the more disabled and shelter-avoiding individuals of the street population.

Finally, about the tenuousness of sites as congregating spots for the homeless, much more will be said below. Suffice it to say here that what may be the case six months before the actual count is by no means assured of being so at the time of actual enumeration. A huge array of largely informal accommodations are at stake in the configuration of street sites at any given point, and the assumption of continuity that underlies the current method of predesignated sites is a risky one.

Reprise

Like “the heath” in Shakespeare’s time,⁶³ “the street” in our own has come to signify a kind of close repository of things evil and alien, and that is a badly damaging mis-

representation.⁶⁴ For every sidewalk Lear — that reckless, ruined king — for whom the street is a public stage for private demons, there are dozens of others for whom it means a rather complicated way of extracting a livelihood from the waste spaces and discarded resources of the city.⁶⁵

The most direct implication this fact has for enumeration efforts is the obvious one: any exposure perceived to compromise an already uncertain existence will be resisted. Contrariwise, the incentive to cooperate with an apparently benign procedure, like a well-publicized census, will be enhanced by provision of resources that ease, at least for the moment, the exigencies of street survival. Hence the prudence of alternatives to wildlife counts that can be linked to desired services and goods.

Shifting Terrain

Ambiguities of site identification and demarcation figured so highly in a companion report on the S-Night monitoring effort.⁶⁶ A few concluding remarks on the unit of observation — the predesignated site — in these studies are therefore in order.

It would be difficult to make too much of the precariousness of the makeshift homes and street sites described here, or of the capriciousness of public policy that determines their fate. A week before the official census count, the police suddenly stepped up round-the-clock surveillance at one of the larger subway stations in lower Manhattan, where in our canvassing forays we had regularly counted sixty people sleeping. On S-Night, project monitors were restricted from observing a team of Census Bureau enumerators by cops posted at the turnstiles. Since March–April, when the observations recounted above were made, a number of other significant changes in the ecology of street homelessness have occurred. Had they occurred but a few weeks earlier, they would have effectively vacated two of the sites in our sample. Here are some of the relevant changes recorded in a *two-month* period; it is by no means an exhaustive list.

Item: On June 1, the Port Authority ordered maintenance crews to keep the pavement outside the Eighth Avenue entrance to the bus station continually wet. Every morning at 6:00 A.M., a team of contract laborers taps into nearby hydrants and begins the operation, ostensibly “to clean the area of debris and urine.” But according to one of the hired workers, the aim is straightforward: “to get rid of the bums.” It is also effective: “They don’t want to sit down and get wet, so they move. It works.”⁶⁷ On July 20, warned by the city’s Environmental Protection Department that the practice violated a local ordinance, the Port Authority curbed the hosing.⁶⁸

Item: On June 3, the M.T.A. began enforcement of its antisleeping regulations in Pennsylvania Station. Upward of 500 people were reported to be staying there at the time.⁶⁹ A night before the scheduled initiation of the new policy, word had circulated among the station’s inhabitants: a count of their numbers around midnight reached only 150; the dozen or so we interviewed had only the vaguest of plans for alternative arrangements. On the designated night, with uniformed police and television media in tow, station officials were able to locate only a single remaining resident.

Item: In early June, the New York City Parks Department cleared out a small encampment of homeless men at the Seventy-ninth Street Boat Basin. Most regrouped in a nearby pedestrian tunnel under the West Side Highway, where they improvised rough sleeping accommodations. Several groups set up camps in adjoining Riverside Park. Just below them, dozens of inhabitants of a long-unused railroad

tunnel, running the two-and-a-half-mile length of the park, were rousted and warned to move on, as construction on the abandoned line resumes.⁷⁰

Item: Ever since the destruction of the elevated sections of the West Side Highway in the midtown area, the numbers living in some improvised dwellings nearby have grown. One substantial waterfront shantytown⁷¹ was located at the end of a recreational pier⁷² next to the *Intrepid* Museum. On July 9, the dozen or so residents were warned that given the imminent start of a construction project to repair the shoring under the pier, they would have to vacate their homemade premises. Human Research Administration outreach workers arrived to offer, without obvious success, the alternative of the municipal shelters; they further advised residents that they would be allowed to return after the construction work had been completed. On July 27, the shantytown was razed by city officials. Residents given two hours' notice, were told not to expect to rebuild and were not allowed to salvage any building materials. Two of the men have found temporary quarters in a storage facility nearby; the rest have scattered.⁷³

Item: On July 15, the Metropolitan Transit Authority (MTA) began enforcing a new policy that prohibits sleeping on the subway trains, especially as they dock in the stations at the end of the line to be serviced.⁷⁴ Sleeping persons allegedly interfered with the maintenance crews assigned to clean the trains. On a single line targeted for the initial enforcement, the MTA reported that some 135 people had regularly been using the trains as home.⁷⁵

Item: On July 25, arson leveled a shantytown built under a remaining elevated stretch of the West Side Highway, at Fifty-eighth Street. According to press reports, roughly a dozen people were living there. One woman accepted a referral to a city shelter; another couple was directed to an emergency assistance unit; with respect to the fate of the remainder, little is known.⁷⁶ Three days after the fire, officials of the New York City Department of Transportation announced plans to check beneath the 846 city-owned bridges, as well as other viaducts and ramps, for homeless people in potentially "hazardous" dwellings. Homeless settlers will be removed, officials said, only where "there could conceivably be a problem" to the structures.⁷⁷

Reference was made earlier to a notional "ecology" of street-level homelessness. But as the foregoing list of actions demonstrates, there is nothing "natural" about the configuration of survival niches on the street. All but one of these disruptions was the product of a deliberate policy decision.⁷⁸ With few exceptions, which were largely ineffective, no provision was made for the resettlement of the more than 700 homeless people displaced in the process.

Little wonder, then, that experienced service providers received the announcement of a street census with a healthy measure of skepticism. As census takers of *housed* populations in New York City were soon to discover, people with a vested interest in remaining undetected — those who are doubled-up, for example, may see little reason to cooperate with an official effort to count their numbers, no matter how strong the reassurances of confidentiality.⁷⁹ How much more so, then, for people whose habitat itself is suspect. Indeed, it must seem a strange endeavor to some for a government so late in acknowledging their presence to be so bent on enumerating it. ♪

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25. J. P. Morrissey, D. Dennis, K. Gounis, and S. Barrow, "The Development and Utilization of the Queen's Men's Shelter" (Albany: New York State Office of Mental Health, Bureau of Evaluation of Research, 1985); S. M. Barrow, F. Hellman, A. M. Lovell, J. D. Plapinger, and E. L. Struening, "Effectiveness of Programs for the Homeless Mentally Ill: Final Report." New York State Psychiatric Institute, Epidemiology of Mental Disorders Research Department, 1989.
26. W. R. Breakey, P. J. Fischer, M. Kramer, G. Neustadt, A. J. Romanoski, A. Ross, R. M. Royall, and O. C. Stine, "Health and Mental Health Problems of Homeless Men and Women in Baltimore," *Journal of the American Medical Association* 262 (1989): 1352–57.
27. J. P. Spradley, *You Owe Yourself a Drink: An Ethnography of Urban Nomads* (Boston: Little, Brown, 1970).
28. J. Wiseman, *Stations of the Lost: The Treatment of the Skid Row Alcoholic* (Englewood Cliffs, N.J.: Prentice-Hall, 1970).
29. K. Hopper, "Public Shelter as a 'Hybrid Institution': Homeless Men in Historical Perspective," *Journal of Social Issues* 46 (1990): 13–30.
30. Episodic homelessness, for example, has been interpreted as just one manifestation of more enduring poverty; see K. Hopper, E. Susser, and S. Conover, "Economies of Makeshift: Deindustrialization and Homelessness in New York City," *Urban Anthropology* 14 (1985):183–236.
31. P. Koegel. Presentation at the Interdisciplinary Symposium: "Broadening Perspectives on the Problem of the Homeless," University of California at Los Angeles, December 1990.
32. Compare, for example, D. Dennis, "Exploring Myths About 'Street People,'" *Access* (published by National Resource Center on Homelessness and Mental Illness) 2, no. 2 (June 1990), with Hopper, "Final Report: Repeat Enumeration," Table 7.
33. Curiously, if one consults a recent study of the *Night As Frontier* (M. Melbin [New York: Free Press, 1987]), in a chapter entitled "Who is Active at Night?" one finds but one mention of "vagrants" or the homeless poor seeking shelter outdoors. For a different impression, see the April 30, 1990, edition of *New York Magazine*, entitled "A Night in the Life of New York."
34. That is, the degree to which these reports accurately captured or recorded what they purported to be capturing or recording, and the relative representativeness of such reports (cf. R. Sanjek, "On Ethnographic Validity," in R. Sanjek, ed., *Fieldnotes* [New York: Cornell University Press, 1990], 385–418).

35. It may not be too much to suggest that for some of the (more privileged) participants a good deal of the felt artificiality may be traced to a realization recently voiced by the poet and literary critic Paul Zweig: "When I was a boy, I used to wonder what would keep me from sinking to the level of a bum on the street. Every tramp, every stinking hulk of a drunk, was a possible destiny. Later, I saw it wasn't so easy to sink. You had to dive, you had to work your way down. Society buoyed you up to your level; family and friends, the structure of needs driven into your flesh and psyche, do not let themselves be easily betrayed" (*Departures* [New York: Harper and Row, 1986], 207).
36. K. Erikson, "A Comment on Disguised Observation in Sociology," *Social Problems* 14: (1967): 366-73; N. Denzin, "On the Ethics of Disguised Observation," *Social Problems* 15 (1968): 502-4; and Erikson, "A Reply to Denzin," *Social Problems* 15 (1968): 505-6.
37. See, for example, J. Cassell and M. L. Wax, eds., "Ethical Problems of Fieldwork," *Social Problems* 27 (1980): 259-377; and most recently, Carolyn Fluehr-Lobban, ed., *Ethics and the Profession of Anthropology* (Philadelphia: University of Pennsylvania Press, 1991).
38. L. Nader, "Up the Anthropologist — Perspectives Gained from Studying Up," in D. Hymes, ed., *Reinventing Anthropology* (New York: Random House, 1974), 284-311.
39. J. Favret-Saada, "About Participation," *Culture, Medicine, and Psychiatry* 14 (1990): 189-99.
40. D. Hurley, "The Homeless: Are Less More?" *New York Newsday*, July 23, 1990, 42.
41. A further caveat: not unexpectedly, given their varied origins, huge differences in education and orientation to field methods, and very limited training, the quality of the field notes submitted by the ethnographers was uneven. I have drawn on the best and most comprehensive for illustrative purposes and made the best I can of the entire set in arriving at generalizations and describing salient patterns. Any numbers reported in the section are obviously provisional.
42. As noted above, this difficulty was accentuated by the ethnographic team's uniform decision to pass as homeless.
43. M. T. Salo and P. C. Campanelli, "Ethnographic Methods in the Development of Census Procedures for Enumerating the Homeless," *Urban Anthropology* 20 (1991): 136.
44. In some sites, getting as much sleep as possible was the norm for the majority of residents.
45. J. Lardner, "Shantytown," *The New Yorker*, July 1, 1991, 67-76.
46. M. Magnet, "Homeless: Craziness, Dope and Danger," *New York Times*, January 26, 1990, A-31.
47. If there is a single index to the relative security many street dwellers felt about their sites, it may be the widespread practice of taking off their shoes before bedding down for the night. Unlike most residents in the public shelters, these men and women do not always make a point of securing their shoes (under bedposts, under their mattresses, as part of their pillows).
48. Though the rules of exchange are a bit tricky here: At one site, giving away cigarettes, when the going rate is 15 cents, was clearly viewed as an indicator of naiveté by the residents; sharing food, which could be obtained from merchants or charity kitchens, was not (Dush and Lee field notes).
49. With the difficulties of visibility firmly in mind, the rough fractions of women at the sites derived from field notes are as follows: Site 1a = 5 of 40; 1b = 5 to 10 per 80-140 residents, almost all women in couples; 2a = 2+ per 23 to 31 occupants; 2b = 0 of 3; 3 = 7-10 per 21 to 40 occupants; 4 = 2 of perhaps 21 seen over five nights, both in couples; 5 = 3 per 30; 6 = 5 per 25; 7 = at least 4 per 30 occupants (half of whom were transient). See footnote to Table 1 for site descriptions.
50. Throwing perhaps another wrench into the operationalization of "homeless person" in the S-Night enumeration.
51. Subsequent investigation of a rather large (some 15-20 residents) midtown shanty settlement disclosed that at least two of its regular women residents did "drive-by" street sex work along the avenues fronting the settlement itself. Their income was probably the most reliable of the group.

52. Two others fended off more casual advances. Several women were approached as well by other homeless men seeking companionship or sex, but other than the usually implicit offer of protection there was no quid pro quo involved. Note that unattached nonblack women in particular, who do not manifest obvious psychiatric disorder, remain a novelty on the streets — two (one of whom was Asian) were explicitly and repeatedly asked whether they were there as part of a class project or protest (Dush, Lee, and Kustwan field notes). A pair of Hispanic women passed the five nights undisturbed, but this may say more about the site than the rarity of their presence.
53. Note, too, in this connection the sources of sexual harassment recounted above.
54. G. A. F. Seber, *The Estimation of Animal Abundance and Related Parameters*, 2d ed. (London: Ch. Griffen, 1982).
55. Hopper, "Final Report: Monitoring and Evaluating."
56. E. M. Laska and M. Meisner, "A Plant-Capture Method for Estimating the Size of a Population from a Single Sample," *Biometrics*, in press.
57. Nor, apparently, is "counting," rather than "estimation," the only practical or logical meaning that the bureau has historically or may legally attach to the term "enumeration." (See [Note], "Demography and Distrust: Constitutional Issues of the Federal Census," *Harvard Law Review* 94 (1981): 841–63; P. Starr, "The Sociology of Official Statistics," in W. Alonso and P. Starr, eds., *The Politics of Numbers* (New York: Russell Sage, 1987), 31; K. K. West and D. J. Fein, "Census Undercount: An Historical and Contemporary Sociological Issue," *Sociological Inquiry* 60 (1990): 134.
58. Like Latin American "squatsments" in this regard, such settlements "are not docketed in the city registries either as individual houses or as aggregates of houses, or places." See A. Leeds, "The Concept of the 'Culture of Poverty': Conceptual, Logical, and Empirical Problems, with Perspectives from Brazil and Peru," in E. B. Leacock, ed., *The Culture of Poverty: A Critique* (New York: Simon and Schuster, 1971), 237.
59. As noted earlier, however, persons posing this question had identified themselves as working with the Coalition for the Homeless, an advocacy and service organization with a good reputation on the street. As Hainer and his colleagues have pointed out, much of the suspicion with which Census Bureau enumerators are met in low-income neighborhoods particularly is tied to general perceptions of "the Government . . . as a monolithic, remote and hostile entity which uses information to hurt the people who provide it" (P. Hainer, C. Hines, E. Martin, and G. Shapiro, "Research on Improving Coverage in Household Surveys," *Fourth Annual Research Conference Proceedings* [Washington, D.C.: U.S. Bureau of the Census, 1988], 522) — a fact of life over which the bureau has no control, but to whose chilling effects the coalition is largely immune. Willingness to identify oneself as homeless may well vary with the respondent's perception of the trustworthiness of the questioner.
60. M. Salo and L. Schwede, "Analysis of In-Place-Observer Debriefings on S-Night Procedures in Five Cities during the 1990 Decennial Census." Presentation at the U.S. Bureau of the Census Annual Research Conference, Arlington, Virginia, March 18, 1991.
61. Farr et al., "Study of Homelessness," 17–57.
62. Salo and Campanelli, "Ethnographic Methods."
63. M. Ignatieff, *The Needs of Strangers* (New York: Viking, 1984), 40–44.
64. J. Toth, "N.Y.'s 'Mole People' Shun Society in Transit Tunnels," *Los Angeles Times*, September 2, 1990, A-1.
65. Scavenging has not always been their lot: for nearly two thirds of those interviewed in the companion study, a job was given as their last source of steady income.
66. Hopper, "Final Report: Monitoring and Evaluating."
67. *New York Post*, July 19, 1990, 5; *New York Daily News*, July 20, 1990, 12.

68. *New York Times*, July 21, 1990, 25.
69. *New York Daily News*, June 1, 1990, 4.
70. *New York Times*, June 13, 1990, A-1.
71. One of the few that was actually enumerated during the street count of S-Night.
72. Taking a leaf from history: in January 1915, the city opened a "recreational pier" on the East River to accommodate the overflow from the Municipal Lodging House; up to 1,500 lodgers slept on cots, and three quarters of the staff were drawn from the ranks of the homeless men.
73. Dave Giffen, Coalition for the Homeless, personal communication.
74. Earlier in the spring, the MTA removed five new benches from a subway platform in Grand Central Station, part of Operation Enforcement designed to "discourage the homeless from living in the subway" (*New York Newsday*, February 27, 1990, 1; *New York Times*, February 28, 1990, B-1). The move was met with a chorus of disapproval, most of which pointed out that it was the riding public who would suffer most. Shortly thereafter, the "experiment" was discontinued and the benches restored.
75. *New York Daily News*, July 13, 1990, 29.
76. *New York Times*, July 26, 1990, B-3; Mary Brosnahan, Coalition for the Homeless, personal communication.
77. *New York Newsday*, July 30, 1990, 6.
78. The exception, of course, is the shanty settlement that burned down.
79. *New York Times*, March 16, 1990, A-1; cf. Hainer et al., "Research on Improving Coverage."

Streets Are for Nobody: Marie

Late thirties; alcoholic home; abused. Found job; now on medical disability; in subsidized housing; attending university.

I remember the first day I ever walked into Pine Street. I had my few clothes and I walked in there and one of the people that worked there asked me if I was hungry and I said, "Yeah." And I went over and I sat down on one of the wooden benches, eating a peanut butter and jelly sandwich, and the tears came streaming down my face, and all I could think of was, "Marie, this is what you have let your life come to?"

[She found an apartment but was lonely and continued to spend time at the shelter.]

And after about two months and a week or whatever, I kind of got used to it and didn't go down as often. I still went and visited. I still go and visit today. But I got . . . I got used to it, used to being by myself. And I actually got to like being by myself. Through therapy I started to learn how to be my own best friend and how to — I'm really enjoying my privacy. I didn't have any idea what was gonna happen — I didn't have any idea what was gonna happen when I used to sit on the bench [at the shelter] or be at night in the park. But I remember the feeling of hopelessness. And here it is five years later and a lot's happened in five years. I am not the same person I was five years ago yesterday, the day I walked out of Pine Street.

[She says homelessness made her realize how lucky she is.]

The amazing thing is that I'm not going around blaming my mother and my father and this one and that one. It's amazing. The amazing part is that I take — I took the responsibility. I know that I was the one that put myself there and I was the one that got myself out of there. And I am the one who keeps myself out of there. Because . . . 'cause it really would be easy to say, "Ah, screw it" and give up. I don't want that. I really don't want it. [Much louder and laughing] I feel so good! 🍌

Interviewed by Melissa Shook, September 11, 1988, South End. Reprinted, with permission, from "Streets Are for Nobody: Homeless Women Speak," Boston Center for the Arts, 1991.

Two Nations

The Homeless in a Divided Land

Shaun O'Connell

The works discussed in this article include:

- Chain Reaction: The Impact of Race, Rights, and Taxes on American Politics*, by Thomas Byrne Edsall with Mary D. Edsall. 339 pages. W. W. Norton, 1991. \$22.95.
- Why Americans Hate Politics*, by E. J. Dionne, Jr. 430 pages. Simon and Schuster, 1991. \$22.95.
- A Far Cry from Home: Life in a Shelter for Homeless Women*, by Lisa Ferrill. Noble Press, 1991. 178 pages. \$10.95.
- Scandal: The Culture of Mistrust in American Politics*, by Suzanne Garment. 335 pages. Random House, 1991. \$23.00.
- Songs from the Alley*, by Kathleen Hirsch. 418 pages. Doubleday, 1988. \$10.95.
- Culture Wars: The Struggle to Define America*, by James Davison Hunter. 416 pages. Basic Books, 1991. \$25.00.
- Rachel and Her Children: Homeless Families in America*, by Jonathan Kozol. 261 pages. Fawcett Columbine, 1988. \$8.95.
- Parliament of Whores: A Lone Humorist Attempts to Explain the Entire U.S. Government*, by P. J. O'Rourke. 233 pages. Atlantic Monthly Press, 1991. \$19.95.
- Down and Out in America: The Origins of Homelessness*, by Peter Rossi. 247 pages. University of Chicago Press, 1989. \$9.95.
- Low Life: Lures and Snares of Old New York*, by Luc Sante. 414 pages. Farrar, Straus & Giroux, 1991. \$18.95.
- The Disuniting of America: Reflections on A Multicultural Society*, by Arthur M. Schlesinger, Jr. 91 pages. Whittle Books, 1991. \$11.95.
- Louder Than Words*, edited by William Shore. 340 pages. Vintage, 1989. \$8.95.
- Voices Louder Than Words: A Second Collection*, edited by William Shore. 322 pages. Vintage, 1991. \$11.00.
-

Husband: "Home is the place where, when you have to go there, /
They have to take you in."

Wife: "I should have called it / Something you somehow haven't to deserve."
— Robert Frost, "The Death of the Hired Man"

We have all known the long loneliness and we have learned that the only solution
is love and that love comes with community.

— Dorothy Day

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In *The Big Money*, the bitterly titled final volume of *U.S.A.* (1936), John Dos Passos decided "we stand defeated America." His Depression-era epic of America in crisis climaxes with the hopeless journey of Vag, a young man on the road, heading west. Cars whip past as Vag winces with hunger. Overhead, a transcontinental plane flies in the bumpy air, while a passenger vomits half-digested steak and mushrooms into a paper carton. "No matter, silver in the pocket, greenbacks in the wallet, drafts, certified checks, plenty restaurants in L.A." Below, Vag continues to walk as more cars head west. "Eyes seek the driver's eyes . . . Head swims, belly tightens, wants crawl over his skin like ants."¹ Juxtaposition here is a method of shock, a mode of understanding.

Lisa Ferrill's contemporary record of life among the homeless, *A Far Cry from Home*, begins with similarly contrasting images. First: "Broadway plays, exquisite views, tantalizing meals served in plush surroundings . . . New York City, city of luxury, city of thrills." Then: "Lines of people waiting to get into a soup kitchen, men, women, and children panhandling on the street, bodies lying over subway grates to keep warm . . . New York City, city of despair." In Dos Passos's example, the rich speed past or fly away while Vag trudges along; in Ferrill's example, the rich consume culture and food behind thick glass barriers, leaving the poor out in the cold, begging, seeking warmth, looking at only their own reflections in the windows. "Often, if we do not *feel* the problem . . . we are not moved to seek solutions." So Ferrill, a social worker at a shelter for homeless women, determines to "walk you," the reader, "through some experiences" so that "you will come to feel as I do — that we cannot afford to keep walking by."²

Much of the literature on the homeless is an assembly of parables — the lives of the homeless, with names changed to protect their identities — designed to shock and move the reader into corrective action, personal and collective. In 1991, a nameless, homeless person once again became the representative citizen of the republic, only now this figure is more likely to be a young woman of color, trapped in a shelter with her children, as she is in Jonathan Kozol's *Rachel and Her Children*, or wandering alone on the streets of the indifferent city.

Ferrill tells us nothing new about New York; since Jacob Riis wrote *How the Other Half Lives* (1890) and *The Children of the Poor* (1892), the problem of homelessness has only compounded. Riis, an immigrant from Denmark who became a police reporter for the *New York Tribune*, stunned America with reports on the conditions of the urban poor, particularly the miserable state of tenement children on the Lower East Side, in the Mulberry Street area. (Some one million Irish, German, and Jewish immigrants, it is estimated, were crowded into approximately thirty-seven thousand tenements in 1880.)³ Riis's still-striking accounts tell a story of New York's decline from gentility and community. The tenements of the poor, he noted, were sectioned out of some of old New York's finest homes, "the decorous homes of the old Knickerbockers, the proud aristocracy of Manhattan in the early days."⁴ For Riis, a bucolic wholesomeness characteristic of old New York had been violated. An ancient cow path became the Mulberry Street "Bend," the "foul core of New York's slums . . . Echoes of tinkling bells linger there still, but they do not call up memories of green meadows and summer fields; they proclaim the home-coming of the rag-picker's cart. In the memory of man the old cow-path has never been other than a vast human pig-sty."⁵ Indeed, a larger pastoral American innocence has been lost. Homelessness, then, is the inevitable by-product of urbanization, where the gap between haves and have-nots is most severe. Though Riis indulged in demeaning ethnic stereotypes, he

also balanced moving portraits of misery with angry complaints against those who benefited from inequity. He showed the poor to be victims of conditions, and therefore not responsible for their plight.

"As a one-man band of social reform, Riis altered the outlook of the whole city, and eventually the nation," in the words of Luc Sante.⁶ Riis's photographs, anticipating those of Lewis Hine, were shocking, but they framed the poor, particularly the children of the slums, with dignity. In a chapter called "The Reign of Rum," Riis wrote: "The rum-shop turns the political crank in New York. The natural yield is rum politics." In such conditions, the city was turning its young men into toughs and its young women into exploited workers and prostitutes, the very models Stephen Crane incorporated in his novel of slum life, *Maggie, Girl of the Streets*. The role of the writer, Crane must have concluded from reading Riis, was to expose the truth of the social situation to readers, who had been conditioned by romantic literature — a literature that would rather have them avert their gaze from authentic misery, and awaken the conscience of the nation.

In "An Experiment in Misery," Crane portrayed a nation whose callous indifference toward the down-and-out was symbolized by New York's arrogant buildings. They were "emblematic of a nation forcing its regal head into the clouds, throwing no downward glances; in the sublimity of its aspirations ignoring the wretches who may flounder at its feet." Crane's prose registered the shock of an outsider in a language of select, symbolic details. "The roar of the city to him was the confusion of strange tongues, babbling heedlessly; it was the clink of coin, the voice of the city's hopes were to him no hopes."

But Crane, the outsider, strained to identify with the "other half." A young man wonders what it feels like to be poor and homeless, so he assumes their tattered garb and lives among the lowly. "Perhaps I could discover his point of view or something near it," concludes the young man. The omniscient narrator then underscores the point: "From those words begins this veracious narrative of an experiment in misery."⁸

In "Curious Shifts of the Poor," (1899) Theodore Dreiser called attention to the destitute who stood in abject contrast to the flashy rich along Broadway. He, too, traced a representative man of New York, "The Captain," in his route to a flophouse. Dreiser described the line of poor outside a mission on Fifteenth Street during a cold January day, a sketch that owes much to Crane's "The Men in the Storm." But Dreiser went out of his way to mute his readers' sympathies. The parade of the poor "before us should not appeal to our pity, but should awaken us to what we are — for society is no better than its poorest type Wealth may create an illusion, or modify a ghastly appearance or ignorance and error, but it cannot change the effect. The result is as real in the mansions of Fifth Avenue as in the midnight throng outside a baker's door."⁹ Throughout his columns for *Ev'ry Month*, Dreiser praised Herbert Spencer's application of Darwin's survival of the fittest theory to social success and failure. "It is only the unfit who fail — who suffer and die," wrote Dreiser, "The Prophet," in 1897.¹⁰

However, Dreiser's acceptance of the harsh ways the other half lived was rare; from the era of the literary naturalists, beginning with Crane, through the Great Depression realists, Dos Passos and Steinbeck in particular, attention has been paid to the poor and the homeless as a way to indict the excessiveness and the callousness of American capitalism. In the Ronald Reagan era, Americans were told that economic "trickle down" would benefit all members of the society; in Oliver Stone's *Wall Street* (1987), a junk bond raider, fittingly named Gordon Gekko, insisted that

"greed is good!" the credo of the Reagan era. So in the 1980s the rich got richer and the poor increasingly became the homeless. As a result, in the 1990s the homeless person has replaced the slick merchant of greed as a representative American.

For Luc Sante, who examined New York's persistent and lurid lower depths in *Low Life* (1991), things have grown far worse since Riis's day, with the introduction of new miseries: drugs and AIDS. The New York poor still are, as they were a century ago, invisible men and women, living in a parallel universe, on the other side of a one-way glass.

To its floating population, New York was a parallel construction, a map of hiding places and safety zones unknown to the general mass of people. To the drifters, the great squares and avenues might scarcely exist, their central place in the city's scheme taken up by back courts and alleys and vacant lots and wharves and the terra incognita in the north of the island before it was urbanized. Their history generally consists of what was seen of them by institutions, charities, police, and journalists; their own lore remained secret or became useless as soon as anybody else learned it. Knowledge of the city's hiding places remains dormant for decades at a time, until it is learned all over again by those who have need of it. Today we can see the destitute finding the niches in railroad tunnels, the abandoned cuttings, the caves of Inwood, and the alcoves under bridge supports that were left for them by previous occupants.¹¹

New York, as usual, only dramatizes a pervasive national problem. In the fall of 1991, in Cambridge, Massachusetts, just across the street from Harvard Yard, the Harvard Bookstore offered a large window display of books about the problem of homelessness. Beneath the display, crouched on the sidewalk, hunched one of the many homeless beggars who station themselves along the major streets around Harvard Square, like guards at the entrances to a walled city, making passage difficult for shoppers and students.

Begging had become an American occupation, just as it had been in the Britain of George Orwell. In *Down and Out in Paris and London*, Orwell noted that begging is "a trade like any other; quite useless, of course — but, then, many reputable trades are quite useless."¹² But is it a job, like any other, that calls for certain skills? The novelist Lynne Sharon Schwartz, writing on New York City's beggars in *Harper's Magazine* in late 1991, thought not. For Schwartz, beggars mirror our own natures. "Who we are is revealed in our response" to their pleas. Responses vary widely, but for Schwartz, in the end it is quite simple: "Either we are our brothers' keepers or we are not. The government's answer has the virtue of being cruelly clear: It is no one's keeper but its own."¹³

However, the nation's compassion was being tested by the increasing number of the homeless in 1991. From sea to shining sea, new techniques and technologies were being developed to "handle" the homeless issue. Manhattan's Port Authority police were removing the homeless from the Eighth Avenue bus terminal and placing them in shelters. "We're going to take the terminal back to its original purpose: a regional transportation facility," said Deputy Inspector Edward Forker. "We're offering the homeless services in a very humane way."¹⁴ The "humane" choices for new shelter sites in New York City were being assisted by an IBM 3090 computer, which surveyed the city for desirable shelter locations. Each section of the city should bear its "fair share" of the problem. Frederick A. O. Schwarz, Jr., chairman of the Charter Revision Commission, said fair share "forces politicians and the public, including

the affluent communities, to think about the fundamental social pathologies causing the problems and not, like Pontius Pilate, to wash their hands of these problems by hiding them.”¹⁵ Yet many of those homeless who had been removed from the Port Authority terminal could be found improvising their own shelters, that is, living in boxes on nearby streets!

Across the land, in Santa Monica, California, where vagrants heading west can go no farther, debate raged over the treatment of the homeless who congregate in alarming numbers in Palisades Park. Santa Monica has long welcomed the homeless. There transient residents were not prosecuted for what city Attorney Robert Meyers calls “crimes of status.” But now so many homeless are present that some permanent residents say the smell of their urine is sharp in the air. One drop-in center serviced forty-five hundred homeless in this city of ninety thousand. David Kingsley, cochairman of the city’s Task Force on Homelessness, said, “There’s absolutely no way a city of this size can handle all of the homeless on its streets.”¹⁶ Was there any way a *nation* of this size could “handle” the vast number of homeless on its streets? Republican presidential candidate Pat Buchanan struck a national nerve when he proposed stricter enforcement of vagrancy laws as a means to contain homelessness. The aggressive homeless were taking over our cities, he said, driving away women shoppers who were frightened of panhandlers!¹⁷

The Cambridge beggar was disheveled, wrapped in layers of mixed-up clothing; he was red-faced, swollen, unshaven, and he stank. “Any spare change?” he asked in a tone of bleak expectations. He was another Vag — now more delicately called one of the homeless — a representative man of the early 1990s. Most pedestrians looked away and passed by. Other walkers in the city gave him some change. Still others slowed, but overlooked him, taking in the texts displayed over his head — those books about the homeless: analysis and compassion under glass. Tolstoy had asked about the Moscow poor a century ago, “What should a man do?” Who knew?

The creative writers of the early 1990s were doing what they could. Two of the books on display in the Harvard Bookstore window were anthologies of short stories contributed by many of the nation’s best fiction writers. *Louder Than Words* and *Voices Louder Than Words: A Second Collection*, both edited by William Shore, were collections of stories donated to Share Our Strength, an organization established in 1984 to raise funds for hunger relief, “now the largest national private hunger relief foundation in the United States,” which distributed over \$3 million in two years.¹⁸ These stories do not set out to portray the homeless, though many depict a sense of vulnerability, as does Anne Tyler’s “A Woman Like a Fieldstone House,” the first story in the first collection, which describes the anxieties a woman suffers every seven years, beginning in 1936, when locust swarms reappear. Perhaps the locust swarms symbolize a condition of precariousness that even the solidly entrenched middle class cannot shut out.

Charles Baxter’s “Shelter” is unusual in its depiction of a direct encounter, in Ann Arbor, between a homeless man and an ordinary citizen, here a twenty-eight-year-old baker. Christine, a cold lawyer, describes Cooper, her husband, as “a latent vagrant.” Cooper is frustrated by his inability to do something about the street people he encounters. When Cooper becomes a volunteer in a shelter, he meets twenty-three-year-old Billy Bell, a wanderer who wants to heal people. When Cooper brings Billy first to his bakery and then to his home for a beer, Cooper’s son becomes anxious and Christine, annoyed at her husband’s “guilty liberalism,” dismisses Billy: “Back

you go. Good-bye. Fare thee well." After a break-in at the bakery, Christine tells Cooper, "I told you so." When his son hides his coin bank so his father will not give away the boy's money, Cooper, vulnerable himself and spreading his anxieties to others, turns to his wife and begs, "Shelter me."¹⁹

This fine story, rich in ambiguities, shows how far the homeless have worked their ways under the skin and into the conscience of some Americans. There but for the grace of something-or-other go I — a realization on which one may cast a cold eye, like Christine; from which one may hide, like their son; on which one may try to act, however fecklessly, like Cooper. Lynne Sharon Schwartz's statement haunts: "Either we are our brothers' keepers or we are not."

William Shore cites Robert Coles, who learned from poet and doctor William Carlos Williams that a life's worth must be measured in conduct, not in writing alone. Such an impulse also moved a number of writers to deliver a benefit reading, also titled "Voices Louder Than Words," in Sanders Theater, Harvard University, in late November 1991. Stephen King, Jamaica Kincaid, and John Edgar Wideman read in the event hosted by Jonathan Kozol. In Cambridge and throughout the land, American writers used their talents to testify, to raise money, to make a difference in the lives of the homeless.

Jonathan Kozol's *Rachel and Her Children* is an impassioned examination of homelessness in America. "Homeless people are poor people," says Kozol, enlarging the context of examination.²⁰ Kozol's strategy of conscience and consciousness appeals to the core American value of the family by suggesting that economic inequities and patterns of institutionalized reform have encouraged the breakdown of family units. (In that model of didactic fiction, *Uncle Tom's Cabin*, Harriet Beecher Stowe appealed to the hearts of Americans by showing how slavery sundered the Christian family.) Homelessness for Kozol results from the increasing economic inequities, which derive from policies of the Reagan era, a proposition that ignores historical patterns of homelessness and overfocuses blame on one source, though it does highlight a clear public policy position of neglect in the Reagan regime. David Stockman, Reagan's candid budget director, said, "I don't think people are entitled to services. I don't believe that there is any entitlement, any basic right to legal services or any other kind of services . . . I don't accept that equality is a moral principle."²¹

"*The cause of homelessness is lack of housing*," insists Kozol.²² This apparent tautology actually leads him to his central concern: the condition of housing for the homeless in New York City. It has developed into an "institution . . . of our own invention, which will mass-produce pathologies, addictions, violence, dependencies, perhaps even a longing for retaliation, for self-vindication, on a scale which will transcend, by far, whatever deviant behaviors we may try to write into their past."²³ Kozol estimated that there were 1.5 million homeless in America in the late 1980s. He projected 400,000 (in a population of 7 million) in New York City by 1990. The homeless are usually marginal citizens who operate with low skills and no family net; often they are young, exploited, people of color, who find they cannot meet the monthly rent. Typically, they are women, often ill or drug dependent, alone with their children — like "Rachel," a woman who both lives in a "shelter" and in constant fear of having her children taken from her by the state.

In 1987, New York City spent \$274 million to provide emergency shelters for its homeless population. For Kozol this public policy choice never addresses the real causes of homelessness; rather, public money supports a system that *creates* an underclass. A sheltered person can wait for eighteen years to enter a public housing

project! So the city chose to pay some \$20,000 a year for a homeless person to live in the Hotel Martinique (at Herald Square, at the intersection of Broadway, Sixth Avenue, and Thirty-second Street) as a temporary shelter. The city paid some \$72 million (nearly half the \$150 million it spent on the homeless) for three thousand families to stay in hotels. (The Martinique received \$8 million.) This “disciplinary agenda” of a “regressive public policy” keeps the city from erecting sufficient low-income housing, even when it would be cost efficient to do so! This, then, “is an agenda of societal retaliation on the unsuccessful.”²⁴

Three years after Kozol’s *Rachel* was published, little had changed in New York City. Writing in the *New York Times*, Dennis P. Culhane estimates that there are now “23,000 shelter beds, which includes 14,000 beds for homeless families” in the city, yet “the shelter has failed as a remedy for homelessness.” Shelters only illustrate the deeper problem: an inadequate national public policy to deal with housing, poverty, mental health, and substance abuse. For Culhane, “the government’s war on poverty [has been] transformed into a war on the poor in the last decade.”²⁵

For all that, what is the alternative to these “temporary” shelters? Kozol reports that the unsheltered homeless sleep, as they did a century ago, in the streets, though now they do not remain decorously removed from middle-class gaze in shantytowns; now the homeless are found in subway tunnels, on street hot-air grates, in train stations, *everywhere*. In Chicago a man sleeping inside a trash compactor was “compressed into a cube of refuse.”²⁶

Yet an ever-increasing number testify against such outrages. Kathleen Hirsch, in *Songs from the Alley*, takes her inspiration and her mission from Robert A. Woods, the founder of Boston’s South End House, who wrote in his book with Albert Kennedy, *The Settlement House* (1922), “Only those who can go among men and women with affection can understand the tissue of objective causes and inward motives which bind people together.”²⁷ Hirsch admires not only what Woods did, but the eloquence and influence of what he wrote. “If [Jane] Addams [founder of Hull House in Chicago] was to become the most prominent practitioner of the settlement house movement, Woods would be its leading apologist.” Together Addams and Woods set out to renew the national covenant of community, which reached back to the Plymouth settlement.²⁸

America needs to be reminded of the nation’s original ideal of community, best expressed by John Winthrop in “A Model of Christian Charity” (1630), a sermon he delivered aboard the *Arbella* before the settlers arrived in the bay of what they called New England. “We must delight in each other, make each others’ conditions our own, rejoice together, mourn together, labor and suffer together: always having before our eyes our commission and community in the work, our community as members of the same body . . . For we must consider that we shall be like a city upon a hill, the eyes of all people are upon us.”²⁹ During the Reagan-Bush era, the homeless have been excluded from the American covenant, shunned, and persecuted, thus revealing the darker side of American puritanism: the impulse to expel or punish those who are unable to affirm the common faith.

In *Songs from the Alley*, Hirsch not only juxtaposes the lives of two women who are homeless, but she plays off the stories of these women, in alternating chapters, against the history of the social worker and settlement house responses to the condition of the homeless, particularly in Boston, where it has long been a major social concern. Hirsch, as a volunteer, an observer, and a journalist, worked for two years in Boston’s Pine Street Inn, “one of the nation’s oldest, and Boston’s largest, shelter for the

homeless." Her experiences separated her from her familiar world. "Stripped of life's sustaining illusions, I saw how easily any one of us can become lost in America."³⁰ It is, of course, Hirsh's literary goal and human intention to strip any remaining illusions about the lives of the "other half" by offering a personal record, which is amplified by scholarship. In every respect her book is a great success.

At its narrative center, *Songs* tells the stories of Amanda and Wendy, two women whose lives include disabilities, psychic and sexual abuse, serious misjudgments, and sustained social rejections. Alas, for all of Hirsch's care in narration, these individual stories of misdirected lives blur into an ur-narrative of misery. A few women recover, many more die, and the rest continue to live on the edge, joined by still more recruits to this other country. "The culture of homelessness is a closed circle that begins in constricted personal lives and completes itself in short-sighted policies."³¹

In the 1980s, Governor Michael Dukakis set out to eliminate homelessness in Massachusetts. In 1984, the Massachusetts legislature passed an omnibus homeless bill, Chapter 450. "Emergency Service" shelters were set up. "By the fall of 1986, Massachusetts' expenditure for emergency assistance had increased from \$6.7 to \$28.5 million in three years. An additional \$8.3 million was being spent on fifty-two family shelters across the state."³² Further, the state spent some \$500 million on housing projects for low-income citizens. Mayor Raymond Flynn of Boston, where the homeless population stood at some five thousand, became the chairman of the U.S. Conference of Mayors' Task Force on Homelessness and Hunger, demonstrating his concern for the homeless. However, by 1991 all that seemed long ago. Though Flynn was still an activist mayor, the city's resources were limited and strained. The number of homeless in Boston had grown. Massachusetts had elected a Republican governor, William Weld, a rigid libertarian who believed in reducing government's commitments to public services. As government at the federal and state level cut its public services, turning away from promises that had been in place since the New Deal, voters wondered what good all that money spent on the homeless had done. The poor and the homeless will always be with us, apparently, so why throw good money after bad? A new callousness had entered the land under Ronald Reagan and hung on through George Bush's first term.

Peter Rossi's *Down and Out in America: The Origins of Homelessness* provides the broadest conceptual framework for the discussion of the topic. Though his book grew out of research into the homeless of Chicago, Rossi sets the homeless in the wide context of governmental policies and national values. For him the condition of homelessness is not defined by a lack of shelter. "Homelessness is more properly viewed as the most aggravated state of a more prevalent problem, *extreme poverty*," a broad, *national* malady.³³ Rossi concludes that "there are 4 to 7 million extremely poor people, persons whose income is below two-thirds of the official poverty line and who are thus at high risk of becoming homeless."³⁴

Rossi's methodology leads him to examine the literature on homelessness, to weigh the statistics for implications, and to include history as well as case histories, collected through interviews. Like others who write on the homeless, Rossi is determined to help the homeless and help prevent further homelessness. His conscious model is Orwell's *Down and Out in London and Paris*. "To be extremely poor or homeless is to be outside the American mainstream: it is unpleasant, unhealthful, and full of pain."³⁵

Rossi's broader perspective makes it clear that homelessness was intensified but not invented during the Reagan-Bush era. In the nineteenth century, "transient homelessness became institutionalized and segregated in American cities."³⁶ Skid rows developed. In the latter quarter of the nineteenth century, homelessness became "masculinized," when migrant workers were mainly men. The peak for skid rows occurred in the early twentieth century, but the hobo and the tramp had largely disappeared in the 1940s. When the Great Depression increased homelessness, The New Deal's Federal Emergency Relief Administration set up camps for transients; then the Works Project Administration provided work for men. World War II reduced homelessness, as did postwar prosperity, but skid rows persisted. Urban renewal of the 1960s and 1970s reduced the housing stock for the poor in cities, but senior housing and Social Security increases protected much of the elderly population against homelessness. Thus, by the end of the 1970s, homelessness had taken on a new character: more people were literally homeless because many of them were less likely to be arrested for public drunkenness and drug abuse; also, deinstitutionalization swelled the ranks of street people. As a result of all these forces, the "new homeless" are far worse off than their earlier counterparts.

Homelessness is everywhere, no longer confined to skid rows. A larger percentage of women (25%) compose the homeless. Now there are many more homeless families on the street. (Young women of color with children are, here again, seen in disproportionate numbers among the homeless.) Many more young (under thirty) have joined the homeless, reflecting the "baby boom" swell. People of color are disproportionately represented in the homeless population. (In Chicago in 1980, blacks made up one third of the population, but they composed 53 percent of the homeless, while whites, who make up 55 percent of the general population, add up to 29 percent of the homeless. Similar patterns are reflected nationally.)³⁷

The new homeless are poorer. Mental illness and drug and alcohol abuse drive people into homelessness, of course, but *disability* is the single dominant trait among the homeless. "The disabled are least able to negotiate successfully the labor and housing markets, to use the welfare system, or to obtain support from family, kin, and friends. Among the destitute, the disabled are the most vulnerable."³⁸ Rossi's only optimistic comment on this condition is that advocates for the homeless are more visible and active than ever before. Rossi calls for a series of government-activist solutions — access to welfare, job training, subsidized housing — with little hope that they will be applied. "The presence of homeless persons is a disgrace in a society that claims to be humane."³⁹

II

All right we are two nations.

— John Dos Passos, *U.S.A.*

Public policies and the popular will combine in a high tide of indifference running against the homeless in the early 1990s. David Duke, running for governor of Louisiana and then for president of the United States, along with other political opportunists, railed against welfare recipients, in transparent code language for people of color, who disproportionately receive those services. Jonathan Kozol reminded us of the apologists of the new selfishness, like Charles Murray in *Losing Ground: American Social Policy, 1950–1980*, who argued that government policy should establish a

"stigma" for single-parent families. Some are just more deserving than others, wrote Murray. "Why is it," asked Kozol, "that views like these, so alien to our American tradition and Judeo-Christian roots, should have received acceptance in this decade?"⁴⁰

Perhaps America no longer *has* a Judeo-Christian consensus. Perhaps instead we have become a nation of warring tribal factions. Certainly the plight of the homeless, like other national maladies, cannot be understood without a discussion of national values. If a nation divided cannot long stand, then a nation at war over its identity and its beliefs cannot muster the will to confront its basic problems. A nation sundered cannot provide for its citizens what Franklin Roosevelt, in January 1941, called the Four Freedoms: freedom of speech and worship; freedom from want and fear.⁴¹

It is the contention of James Davison Hunter, in *Culture Wars: The Struggle to Define America*, that "the contemporary culture war is ultimately a struggle over national identity — *over the meaning of America*, who we have been in the past, who we are now, and perhaps most important, who we, as a nation, will aspire to become in the new millennium."⁴² Our current divisions may be the most serious crisis the nation has faced since the Civil War. We *are* two, if not more, nations.

Hunter's study allows us to set such problems as the crisis in homelessness in the broadest context of the national debate over those basic values which either join us as one people or set us at each other's throats. Of course, as mention of the Civil War reminds us, such divisions are not new in the republic. But the cultural discords of the nineteenth century, expressed most dramatically in religious hostilities, have apparently been healed or ignored by twentieth-century tolerance or indifference, so the suggestion that we are now undergoing an intense culture conflict may seem odd. However, Hunter's fine book makes it clear that this new cleavage cuts across the lines of old religious divisions, which had previously balanced out in the Judeo-Christian consensus of tolerance. At odds now are "*the impulse toward orthodoxy*" versus "*the impulse toward progressivism*."⁴³ Conservative or moral traditionalists oppose liberals or moral progressives. This, then, is a struggle for power and a battle for the minds and heart of America.

Within the ranks of America's well-established religions, ideological differences have grown into orthodox and progressive wings, new alliances most dramatically seen in the debates over abortion, gender roles, and the definition of what constitutes a family. "The new ecumenism, then, represents the key institutional expression of the realignment of American public culture and, in turn, it provides the institutional battle lines for the contemporary culture war."⁴⁴

The orthodox are, on the whole, politically conservative and the progressives are usually politically liberal, "but those tendencies . . . are merely the *political manifestations of still deeper commitments*. In reality orthodox and progressive alliances do not operate on the same plane of moral discourse What ultimately explains the realignment in America's public culture are *allegiances to different formulations and sources of moral authority*."⁴⁵ Each side tries to marginalize the other and claims for itself the mainstream American tradition. Each side is intransigent in its righteousness. Exacerbating the problem, media coverage tends to fix upon extremes rather than seek a center. "Among the weaknesses in both orthodox and progressivist alliances, then, is an implicit yet imperious disregard for the goal of a *common life*."⁴⁶

For Thomas Byrne Edsall, writing with Mary D. Edsall, in *Chain Reaction: The Impact of Race, Rights, and Taxes on American Politics*, America also lacks a common life. "The overlapping issues of race and taxes have permitted the Republican party to adapt the

principles of conservatism to break the underlying class bias of the Roosevelt-Democratic coalition and to build a reconfigured voting majority in presidential elections.” Race has been the wedge used by Republicans to divide the Democrats, with the issues surrounding taxes used to remind whites of the costs of Democratic “fairness” programs. All of this creates a “chain reaction — a point of political combustion reached as a linked series of highly charged issues collide,” impacting, in particular, “two key swing voter groups, the white, European ethnics, often Catholic, voters in the North, and the lower-income southern white populists.”⁴⁷

The Edsalls trace this political reorientation back to the radical, racist Dixiecrat movement of 1948; down through Barry Goldwater and George Wallace, who lost elections but showed that there were votes to be gained by playing the black card; finally, to the Southern strategy of Richard Nixon, a successful appeal to white Southerners (and Northern laborers), a solicitation then utilized by Reagan and Bush. This Republican strategy neutralized the Democrats by tying them to those who can be portrayed as “marginal interest groups”; Republicans claimed the center of the electorate — increasingly white, suburban, those concerned with “family values,” leaving the inner cities (sites of crimes increasingly identified with racial minorities) to the Democrats and their “special interest” groups — that is, those, in one way or another, without “traditional” family orientations. This chain reaction formed a potent political fusion, blowing Democrats out of presidential elections.

In their fine study, the Edsalls nicely depersonalize politics. They do not, for example, dwell on the persuasive powers of Ronald Reagan’s charisma, but rather they properly see him as the front man for a conservative movement that preceded and succeeded him. The Edsalls are less concerned with character and more concerned with context. As did Hunter in *Culture Wars*, the Edsalls see a nation at war over conflicting visions of itself: “one of individual initiative and equal opportunity (Republican), the other of welfare dependence and anti-egalitarian special preference (Democratic).”⁴⁸

The Democratic Party has lost five of the last six presidential elections and in 1992 faces an electorate in which largely white suburban voters constitute a majority. But more is at stake than the future of the two-party system in presidential politics. “At stake is the American experiment itself, endangered by a rising tide of cynicism and alienation, and by basic uncertainties as to whether or not we are capable of transmitting a sense of inclusion and shared citizenship across an immense and diverse population.”⁴⁹

Certainly there were other ways in which American divisions, the nation’s culture wars, were accounted for, some silly, some searching, but none that conveyed much cheer about the state of the nation. On the trivial pursuits side of analysis, P. J. O’Rourke’s *Parliament of Whores* ranks high. O’Rourke describes himself, in his subtitle, as “A Lone Humorist [Who] Attempts to Explain the Entire U.S. Government.” A fair example of what he calls humor is captured in the title, set in screaming capital letters, to one of his book’s sections: “OUR GOVERNMENT: WHAT THE FUCK DO THEY DO ALL DAY AND WHY DOES IT COST SO GODDAMN MUCH MONEY?”⁵⁰ O’Rourke — a bush-league H. L. Mencken and Hunter S. Thompson clone, a *Rolling Stone* contributor who writes pop rock-and-roll prose, a wise guy who makes simplistic, sweeping, and cynical judgments — writes from a reactionary, antigovernment point of view. “I have only one belief about the political system, and that is this: God is a Republican and Santa Claus is a Democrat.”⁵¹ It is a sign of the times that O’Rourke’s crude rants have made him a popular author. O’Rourke’s guide

to the national political system constitutes a parody of the kind of civics-and-government courses we once took in high school. "The three branches of government number considerably more than three and are not, in any sense, 'branches' since that would imply that there is something they are attached to besides self-aggrandizement and our pocketbooks."⁵² It is difficult to see what O'Rourke is attached to beyond self-aggrandizement and the swelling of his own pocketbook by writing columns and books that pander to the fears and suspicions of Americans through his personification of government as the nation's problem rather than the potential source of solutions. *Parliament of Whores*, high atop the best-seller lists, exemplifies the dumbing-down of discourse in America.

Of course our high school civics-and-government classes *do* need considerable reconsideration if we want to understand how some things work in Washington and why others do not. Suzanne Garment's *Scandal: The Culture of Mistrust in American Politics*, also written from the politically conservative point of view, describes our "culture of mistrust" with more searching and sustained powers of analysis, though with her own curious conclusions.⁵³ Her book focuses on several political scandals of the recent decades, suggesting, amazingly enough, that most were much ado about very little, even Watergate! Scandals, Garment implies, are mere theatrical distractions from the true systemic problems of the republic. Scandals allow us to moralize rather than analyze. Sexual misadventure and money grabbing present characters of concupiscence and cupidity in a national soap opera — *The Days of Our Lives* as a political passion play. In the 1970s and 1980s in particular, "sex-related political scandals mesmerized us with their lurid dramas of passion and weakness, crime and punishment."⁵⁴ From revelations about John Kennedy's infidelities to John Tower's womanizing, sex scandals have titillated and distracted, but they have not enlightened the political process.

In the end, Garment is far more interested in attacking scandalmongers, particularly the press, than in criticizing those who commit deeds that are the focus of scandals. The culture of mistrust for Garment rose out of the Vietnam War protest era, *not* out of any measurable increase in the corruption of its public officials. "Today's ethics police practice scorched-earth warfare of a sort readily recognizable from Vietnam days," days when antiwar activists, in Garment's view, were indifferent to the pains caused by their protests.⁵⁵ Strangely, Garment writes as though there had been no just cause for protest over American involvement in Vietnam. For her, a post-Watergate press (which hides in the bushes to track Gary Hart's sexual escapades) and the presence of special prosecutors (later renamed independent counsels) by Congress — as in the case of Raymond Donovan, Reagan's secretary of Labor, who was investigated for six years with inconclusive results — have unleashed a new Puritanism in the land.

As Nicholas Lehman, writing about *Scandal* in *The New Republic*, rightly says, for Garment "the real issue is not ethics, but ideology. She sees the rise of ethics scandals in the 1970s as a byproduct of the rise of an elite of left-wing journalists, intellectuals, lawyers, and bureaucrats, who shared a 'conviction that the people governing this country were fundamentally illegitimate in their claims to authority and criminal in their behavior.'"⁵⁶ No doubt, as she further argues, some of those subject to scandalous revelations were indeed publicized by disgruntled liberals who were motivated to attack Nixon, Reagan, and Bush because Republicans so firmly held control of the White House. However, it does not necessarily follow from this, as Garment seems

to imply — as it did not follow from Richard Nixon's assertion that he was not a crook — that occasions worthy of scandal do not occur (or that Richard Nixon was not a crook). That is, as paranoiacs sometimes have real enemies, scandalmongers often have real corruptions to uncover, as they did in revealing the secret maneuvers of Richard Nixon and Oliver North. In any case, whether the problem lies in those who perpetrate or publicize scandals in government, as these books by O'Rourke and Garment indicate, a divided America is reflected in an increasingly angry, disenfranchised, suspicious electorate.

However, E. J. Dionne, Jr., in *Why Americans Hate Politics*, offers a broader range of evidence and a far more searching analysis of the problem, which Jimmy Carter once called our national malaise. Dionne examines thirty years of political history in "an attempt to trace how we got here and why liberalism and conservatism have become obstacles to a healthy political life."⁵⁷ America, for Dionne, is suffering from "a false polarization" of issues, a division shaped during the 1960s in the argument between liberals and conservatives. With the decline of a "politics of remedy" and an increasingly alienated electorate — composed of those who think individually rather than those who identify with groups — campaign issues have become polarized.⁵⁸ Like Hunter in *Culture Wars*, Dionne in *Why Americans Hate Politics* sees a divided land. "War" and "hate" have now become the revealing terms in which we discuss the state of the nation.

The New Left "polarized American life around false issues and false choices. In ways it did not intend, the New Left also played a decisive role in undermining liberalism's influence on American life." Also: "Conservatives need a politics of false choices Conservatism badly needs the failed old liberalism; without such an enemy, conservatism could fall apart."⁵⁹ Dionne, in his plague-upon-both-houses approach, seeks a point of resolution beyond these simplistic alternatives. At his best he reconceptualizes polarizing political rhetoric and urges each side to heed the other seriously, as he does when he talks about the Republicans' exploitations of "traditional values" during the 1988 presidential campaign. "Michael Dukakis spoke contemptuously of the Republicans' campaign of 'flags and furloughs.' But flags and furloughs spoke precisely to the doubts that many Americans developed about liberalism from 1968 onward. In the eyes of many of their traditional supporters liberal Democrats seemed to oppose the personal disciplines — of family and tough law enforcement, of community values and patriotism — that average citizens, no less than neoconservative intellectuals, saw as essential to holding society together."⁶⁰

In his drive to discover a new consensus, Dionne brings a rare understanding of the noble motives of those who hold conflicting positions; this is apparent in his discussion of the debate over abortion. "Prolife and prochoice women had different values; they therefore made different life choices; and they thus developed different resources and different economic interests. In the abortion debate, each side defends not only a heartfelt position on a difficult moral question but also an entire way of life. Thus did a war over values become a class war. The class war was made even more bitter by a religious war, since very religious people were much more opposed to abortion, on the whole, than others."⁶¹ So, then, reasonable Americans disagree because they live in universes of quite different values. The result is a society divided by uncivil warfare.

In his final chapter, "The Politics of the Restive Majority: Healing Public Life in the Nineties," Dionne recaps and turns to solutions. His study demonstrates the false alter-

natives offered by the Left and the Right. As a result of being forced to decide between these stark options, the American electorate has soured on the political process. What is needed is a will to compromise and a more complex vision of *problems*, which can be solved, not *issues*, which merely position candidates in their debates. Thus the book takes a positive turn, as it of necessity must, lest Dionne join those who perpetuate the politics of exaggerated options.

But his optimism seems unfounded, given the more than three hundred pages of detailed discussion of willful misrepresentations that precede his final chapter. His solutions, as well, are unconvincing, for they assume good will and a high-minded commitment to the public good on both sides of the debate, qualities nowhere else in evidence in the text. "For both the Sixties Left and the Eighties Right, politics became the arena in which moral and ethical questions could be settled once and for all."⁶² Both sides were driven by a moralism that blinded each faction to complex realities and cheapened the motives of their opponents. Real problems — the loss of industry to Japan and Germany, the declining standard of living for Americans, increased racism, neglect of the nation's children, an inadequate health care system, and the increasing presence of the homeless — were not dealt with; such problems of public policy were acknowledged but not debated in the 1988 presidential campaign. (Before the New Hampshire primaries in 1988, nearly all the Democratic presidential candidates accompanied Boston's mayor, Raymond L. Flynn, to a city-run shelter for the homeless. Before the New Hampshire primaries of 1992, though invited by Flynn, no Democratic candidates came.)⁶³ "Thus, when Americans say that politics has nothing to do with what really matters, they are largely right . . . Americans hate politics as it is now practiced because we have lost all sense of the public good."⁶⁴ This, then, is Dionne's call to common citizenship, for "a nation that hates politics will not long survive as a democracy."⁶⁵

"America has traveled a long way from the days of the late 1940s when Arthur Schlesinger, Jr., proclaimed his *Vital Center*," adds Dionne. "America, as it turned out, had a lot of fighting to do over the fundamentals, from war and peace to race and feminism."⁶⁶ No one realizes this better than Arthur Schlesinger, Jr., whose brief book *The Disuniting of America: Reflections on a Multicultural Society* eloquently described and analyzed the bifurcated state of the nation in 1991.

Schlesinger's impassioned essay begins and ends with the question posed by J. Hector St. John de Crèvecoeur in *Letters from an American Farmer* (1782): "What then is the American, this new man?" Schlesinger celebrates Crèvecoeur's answer: "The American is a new man, who acts upon new principles . . . Here individuals of all nations are melted into a new race of men."⁶⁷ The purpose of Schlesinger's essay, then, is to reaffirm the commitment to the idea of America, as a whole — unity through the "pursuit of happiness" by individuals rather than groups. Crèvecoeur's words constitute "still a good answer — still the best hope."⁶⁸

To develop his thesis about the persistent promise of American life, Schlesinger asks for one rhetorical concession. In responding to Crèvecoeur's question about "a new man," Schlesinger suggests "twentieth century readers must overlook eighteenth-century male obliviousness to the existence of women."⁶⁹ Of course, it is just this that many modern readers will *not* willingly "overlook." Feminists are more likely to heed Abigail Adams's injunction to her husband John, who was helping to frame the Constitution, to "remember the ladies." However, we should recall that she was urging that the framers *include* women in the polity of the republic, not that they receive

preferential treatment. Still, Schlesinger's argument flies in the face of much politically correct thinking, which emphasizes gender, race, ethnic, and other minority exploitation from the American consensus. But Schlesinger holds that such concerns, while understandable in a nation that *has* exploited and suppressed, by groups, its citizens, has gone too far, that too many Americans have lost a sense of national identity and purpose: what Gunnar Myrdal called the American Creed of democratic union of diverse peoples.⁷⁰

Franklin Roosevelt, rallying patriotism in 1943, said, "Americanism is not, and never was, a matter of race and ancestry. A good American is one who is loyal to this country and to our creed of liberty and democracy." Schlesinger grants that these ideals in practice "applied only to white people," yet, sustaining his dialectical mode of argument, he reminds us, as Myrdal has previously pointed out, that these ideals of the "American Creed," however compromised, were the basis of hope for exploited and disadvantaged peoples, the "huddled masses" who came to America in search of a new life.⁷¹ Now conflicts over civil rights — a new emphasis on racial, gender, ethnic, and other minority rights — have turned many Americans away from this bonding creed. A new interest in roots, racial and ethnic pride, has developed. "The rising cult of ethnicity was a symptom of decreasing confidence in the American future." For Schlesinger, the new "cult" of ethnicity "threatens to become a counter-revolution against the original theory of America as 'one people,' a common culture, a single nation."⁷²

Schlesinger reminds us that, despite our newfound nativism and ethnocentrism, "for better or for worse, American history has been shaped more than anything else by British tradition and culture."⁷³ He singles out the Irish and the Jews as representative groups who first suffered in America but finally succeeded. Schlesinger sympathizes with the special condition of American blacks — who did not come to America willingly, who have been here longer than the Irish and the Jews, and who have been continuously stigmatized and oppressed — but he believes that some blacks have gone too far in advocating "Afrocentricity." Schlesinger is particularly critical of the revisions made in the New York State school system's history curriculum, which "takes no interest in the problem of holding a diverse republic together. Its impact is rather to sanction and deepen racial tensions."⁷⁴ Schlesinger believes that American blacks, like other groups before them, are inventing a flattering history to compensate for injustices inflicted on them. But this is "*bad* history."⁷⁵ "Let us by all means teach black history, African history, woman's history, Hispanic history, Asian history. But let us teach them as history, not as filiopietistic commemoration."⁷⁶

Schlesinger characterizes the proponents of multiculturalism as self-serving chauvinists, as distorters of the historical record, as cultural fragmenters who undermine the cohesive idea of "America" as one people. "Multicultural zealots reject as hegemonic the notion of a shared commitment to common ideals. How far the discourse has come from Crèvecoeur's 'new race,' from Tocqueville's civic participation, from Emerson's 'smelting pot,' from Bryce's 'amazing solvent,' from Myrdal's 'American Creed'!"⁷⁷ For Arthur M. Schlesinger, Jr., who once described America's "vital center," Crèvecoeur's uniting vision is still vivid: "Americanization has not lost its charms."⁷⁸

For most of the commentators on the state of the nation, though, America had lost far more than its charms: it had lost its vital center of coherence and cohesion. "Things fall apart; the centre cannot hold." Seventy years after Yeats wrote those

lines, in response to an Ireland in a time of civil war, America too seemed to be "turning and turning in the widening gyre."⁷⁹

III

During a cold snap in early December, I was again rushing past the Harvard Bookstore in Cambridge. I noticed that the window display on the homeless had been changed to an array of Christmas gift books, all on the subject of food. *The Joy of Cooking* and other texts offered bright covers with bright pictures of sumptuous repasts. The homeless beggar who had stationed himself on the ground beneath that display window in November was also gone. Had he moved to a better location for donations? Had he retreated from the cold into a shelter? Was he dead? Who knew? Who, in America, cared? On Christmas Day 1991, the *New York Times* called attention to "the virtual disappearance of homelessness from the political debate" of the 1992 election campaigns. With the worsening economic conditions of the nation, callousness toward the homeless, whose number is increasing at an alarming rate, was also increasing at an alarming rate.⁸⁰

Yet many Americans *do* care. Just before Christmas, writing in the *New York Times*, Anna Quindlen called her readers' attention to one affluent New Yorker, Harold Brown, a vice president in futures and options at Dean Witter, who grew so distressed at the sight of the homeless who were huddled on subway grates for warmth that he and his wife did something about it. They opened a shelter in a church basement in Queens. Some, like the Browns, do what they can. Others, like Quindlen, testify.

The important thing to remember about Christmas is not closing time at Macy's; it is the story of a pregnant woman and her husband who turned up looking for a bed for what some still think was the most transformative event in history and were told to get lost. The irony of the fact that there is no room at the inn for millions in this country is potent at this time.⁸¹

Despite such heroic actions and such eloquent testimonies, the irony is lost on our leaders. As Lynne Sharon Schwartz put it, the government "is no one's keeper but its own." As America has further divided against itself, the homeless have been largely shut out of the shining city upon a hill. ❧

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38. *Ibid.*, 195.
39. *Ibid.*, 210.

40. Kozol, *Rachel*, 137. Charles Murray published a May 1985 essay in *Commentary* titled "Helping the Poor: A Few Modest Proposals," a title which alludes to Swift, but takes the narrator of Swift's "A Modest Proposal" — who argued that the excess offspring of the poor should be sold, killed, and dressed for food — unironically. *Ibid.*, 236.
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